HEALTH CARE CRISIS: PROBLEMS OF COST AND ACCESS

HEARINGS

BEFORE THE

TASK FORCE ON HUMAN RESOURCES

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

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HEALTH CARE CRISIS: PROBLEMS OF COST AND ACCESS

THURSDAY, AUGUST 23, 1990

HOUSE OF REPRESENTATIVES,
TASK FORCE ON HUMAN RESOURCES,
COMMITTEE ON THE BUDGET,
Fresno, CA

The Task Force met, pursuant to notice, at 9:30 a.m., in City Council Chambers, Fresno City Hall, 2326 Fresno Street, Fresno, CA, Hon. Barbara Boxer, Chair of the Task Force, presiding.

Mrs. BOXER. Good morning. I am Barbara Boxer, and I am the Chairperson of the Budget Committee's Task Force on Human Resources.

This Task Force I have been the Chair of for 2 years is really responsible for all of the health care budget of the Government of the United States of America.

I want to welcome you to these field hearings, which will be held today in Fresno and continue tomorrow in Modesto.

The Task Force is charged with the responsibility of recommending funding levels for health and education programs to the full Budget Committee. During the 2 years of my chairmanship, the Task Force has highlighted some of our most critical health care and education needs. Over the last year, the Human Resources Task Force has held hearings on AIDS, on Medicare, biomedical research, veterans' health care, and children's programs including the WIC Program, the special supplemental nutrition program for women, infants, and children.

The people best able to advise us on health care issues are the people fighting the battles on the front lines. We are here today to find out how people in our California communities are coping and to identify key problems and perhaps some innovative responses and take all of this back to Washington.

We are aware of some shocking statistics. As many as 37 million Americans have no health insurance coverage at all. Medicaid serves only about half of our poor children, while 20 percent of our children are below the poverty line. The United States ranks behind 19 other nations in infant mortality rate; that is, behind 19 other industrialized nations. A child born in Cuba has a better chance of surviving than a child born in Washington, DC, in this great Nation. Over 70,000 babies are born every year to women who have had no prenatal care. These figures are very disturbing.

I have long advocated an approach to health programs based on the cost-effectiveness of early intervention. We have to reach out to people before they are ill or pregnant or hooked on drugs.

This hearing could not be more timely. We are waiting for the budget summit to resume. The budget resolution assembled by the Budget Committee, and approved by the House, assumed large funding increases for the National Institutes of Health, Medicaid, and other programs for our children, and it held the line on Medicare cuts asked for by the Bush Administration. Unfortunately, these gains are threatened by the recent economic downturn and differences in priorities between Democrats and Republicans.

We are bringing together today local elected officials, health care providers and community activists to dramatize health care issues. By your testimony, you can help me bring the truth about health care to the summit negotiators in Washington and to the U.S. Congress. So I really want to thank you very much.

It is my privilege at this time to call forward our first witness, Hon. Karen Humphrey, the Mayor of the city of Fresno.

Madam Mayor, welcome, and I am very interested to hear your testimony.

STATEMENT OF HON. KAREN HUMPHREY, MAYOR, CITY OF FRESNO

Ms. HUMPHREY. Thank you, Congresswoman Boxer. I am indeed privileged to be here and I want to welcome you and your staff and the people who are involved in this effort to the city of Fresno. It is one of the fastest growing cities in the San Joaquin Valley, which is one of the fastest growing areas of California. And among the many challenges that we face, health care is a major issue for us.

I am really pleased that you are here looking at health care issues. We are under increasing pressure in the Fresno area as elsewhere in the State, but I think you will hear some specific issues for the central valley here, due to not only changes in Federal policy but you may have heard about our recent State budget crunch in which a number of the cuts are going to severely affect the providing of health care services in the Fresno area as well as throughout the State.

We have our own Valley Medical Center which is under tremendous pressure and will be under more due to the State budget cuts. But it also affects other agencies. In fact, one of the things that we are aware of as city officials, and as you well know, cities do not directly provide health care, except the health insurance that we provide to our own employees, and we are always, of course, confronted with the rapidly rising cost of that. But we are not responsible for providing Valley Medical Center or the health services. The county is the arm of the State which does provide that. However, we are very sensitive because it is, of course, the citizens of Fresno who are deeply affected by what is going on.

And we have seen the problems for Fresno residents develop over the years. We are aware of the hospitals in the community, not just Valley Medical Center, but the private hospitals as well who are under pressure because of inadequate reimbursement from either Medicare or Medi-Cal services they provide. And we are very

interested and supportive of the positive changes that may come in Federal policy to address some of the needs, particularly of access to health care and the cost of health care in the San Joaquin Valley.

As I said, we are not directly involved with providing health care but we are really concerned with health issues and not just physical health issues. We see them as a piece of the health of the entire community. And there are many issues in which we have a linkage in the relationship to these issues. And in which decisions in those areas are going to affect the actual direct health care system.

The clear and most important one, in terms of direct impact on the city of Fresno, of course, is the whole area of drug and alcohol abuse. At least two-thirds of our police problems relate in some way to drug and alcohol abuse. It is a severe physical health problem. It is also a severe social health problem. And I could not agree more with your own focus on early intervention as a key to that.

We are very concerned about the effect of drugs and alcohol, particularly on our youth, and whatever can be done in terms of involving the Federal Government in efforts to build early intervention programs and to stop the problems before they begin is going to pay off enormously in lowered police costs and lowered criminal justice costs and the lowered cost of lost lives down the road. This is an economic issue as well. The loss in productivity and the impact on our economic climate and our economic health is significant from this problem.

We have a very great focus on environmental health issues in the San Joaquin Valley. I think you can probably argue that the San Joaquin Valley is a microcosm of the environmental issues that confront the United States right now, and we are hoping that there will be some very positive steps taken. Air pollution. We are living in the middle of a basin that potentially could be the worst air pollution basin in the country. And the city of Fresno has taken some strong policy steps toward what we can do to address air quality issues, but it is becoming a continuing issue, a growing issue, of health and I think that there are professionals in the community who can tell you about the impact they are seeing, particularly on children's health, from air quality issues.

Water issues are a major one. We have severe water contamination problems in the city of Fresno. We are working very hard to deal with them because we want to be sure that our citizens are drinking safe water, but providing an adequate supply of that to meet the needs of a growing community is becoming an increasing challenge. Frankly, Federal and State involvement in these issues is important.

We are working in terms of the providing of health care facilities. The city of Fresno is now one of five partners in an effort to create a regional medical center complex in our central area which would have a number of benefits. The first and foremost would be providing of health care from a unified facility where services could be shared, where there could be efficiencies, economies of scale, where the institutions could work together in a symbiotic fashion and the benefits for the city of Fresno beyond an improved health care delivery system is that it would be the sparkplug for major redevelopment in our central area. And we are working very

hard with Valley Medical Center, the county of Fresno, Valley Children's Hospital, Fresno Community Hospitals, and the University of California Medical School to try to make that come to pass. So we are very actively and directly involved.

The city of Fresno—I like the fact that you are focusing on children and youth issues in this hearing. The city of Fresno for the first time in its history has adopted formal policies on children and youth. We did so recently. And while they are probably still in an infant stage, they are, I believe, a clear commitment of the city to the needs of our children and to structuring city programs that will help meet those needs. The emphasis in those policies is on the concept of partnership. Partnership with community agencies that deal with the needs of children. Partnership with other levels of government that can help us meet those needs. And I think that that perhaps is a growing theme in Government and we need to be sounding it very loudly.

My request is that in the context of your hearings that you look as much as possible at how the agencies and the people who are concerned with the health of the community can be working together and can share the appropriate levels of resources to really truly meet the needs that you are identifying.

You have offered some very frightening statistics. We have another statistic that I was told recently is that at any one time in the course of a year up to a quarter of our citizens, 25 percent, which probably comes to double the number of those who are totally without health care, that sometime during the year up to 25 percent of our citizens are without health care at least for a time.

That is very frightening to me. I have gone through periods of time in my job history where I was not employed with somebody who had a health insurance program and had to either cope with my own or depend on my husband's health insurance or whatever I could do. It was not a significant issue for me and it was something that was remedied fairly fast. But I think that this is a very frightening and real and everyday problem for millions of our citizens, and we really need to address it. I think we have a crisis on our hands.

The city of Fresno has taken a larger and larger role in terms of identifying itself as concerned with the overall quality of life in our community. We no longer define our role as being just involved in the provision of basic municipal services. We try to put those basic municipal services, provide them very well, but put them in the context of a commitment to quality of life and to improving the quality of life for all of our citizens. We are prepared to be a partner. We think that it is important that everybody accept a share of their responsibility in that those responsibilities be apportioned in the appropriate manner. And we know that the Federal Government's ability to marshall resources and set policy is critical to that partnership.

So I am delighted that you are here today. I thank you for your concern and for the work that you are doing. We will look forward to hearing your specific proposals. And we hope that you have a very successful day and that you get a good taste of the friendliness of the people of Fresno. They are very good people.

Mrs. Boxer. Thank you so much, Madam Mayor.

Ms. HUMPHREY. Thank you

Mrs. BOXER. Before you leave, I just want to make a couple of points.

I started my public life in local office myself as a member of the Board of Supervisors of Marin County, and worked with many Mayors and city council people at that time, and have since.

And as we talked, when I asked you to speak, you said, "I'm glad that you asked me, Congresswoman, but we don't get involved in health care in the city."

But what I wanted you to do today, you have done. What you have shown us all is the link. In other words, if we do not have prevention, and if you have to deal with the fallout of drug use, abuse, alcohol abuse, people who are staggering because they do not have health insurance, it affects what you do, your law enforcement, your economic health. I think that's the important point that you are making and you made it very eloquently. I really want to thank you very, very much, and I look forward to working with you.

Ms. HUMPHREY. Thank you. While I appreciate your making the request because as soon as you start to think about these things, you realize the linkage and it is important that people understand at every level of government, and really in every community organization, that we all have a role and what we are trying to do in the world is affected by what is happening with others, so we do not get back to the old idea of no man is an island and no person is an island. We are just not functioning in isolation.

I thank you for giving me the opportunity to raise those points.

Mrs. BOXER. Thank you very much, Mayor Humphrey.

Ms. HUMPHREY. I wish you a very good day. Thank you.

Mrs. BOXER. I just wanted to make a comment regarding the way we will proceed.

Under Congressional rules and Budget Committee rules, the people who will speak will be panels that have signed up and worked with the staff for the last month. This hearing has been put together over a month ago.

Anyone who wishes, I have made a special request and it will be granted, that if you are not one of the panelists and you would like to have a statement included in the record of the hearing to be brought back to Congress, we will be very happy to leave the record open, and I will check with staff at the end of the hearing, and I will let you know, and we will be very happy to submit whatever statements other people may have.

To the people holding the sign, I want you to know that I did see the sign and we will not be discussing fetal research today. And if you want to stand there with it, it is just fine with me, but I have in fact seen the sign.

A VOICE FROM AUDIENCE. Thank you.

Mrs. BOXER. Our first panel will please come forward. George Bleth, director, Fresno County Health Department; Bertha Felix-Mata, Madera Family Health Center; and Dr. John Telles, physician.

Are you all here? Is Dr. Telles here? Please come up.

We have your written statement, Mr. Bleth. If you would like to, you can summarize it and try to keep your comments to, oh, seven

or eight minutes if you can, and then we will proceed. And then I will ask questions following each of the panel's presentation.

STATEMENT OF GEORGE BLETH, DIRECTOR, FRESNO COUNTY HEALTH DEPARTMENT

Mr. BLETH. Thank you, Congresswoman Boxer. On behalf of the Fresno County Board of Supervisors, welcome to Fresno County.

Mrs. BOXER. Thank you very much.

Mr. BLETH. To you and your staff.

As you have indicated, I have submitted written testimony. For the sake of brevity, so we can get into an exchange of ideas or concerns, I will just briefly go through it.

Mrs. BOXER. Please.

Mr. BLETH. As you know, Fresno County is one public agency in the State that has felt the impact of the reduction of funding which we consider and which I consider demonstrates a lack of commitment to the poor and the uninsured throughout the State. I think we are experiencing this nationally.

The recent budget process in the State of California has made this known to us very forcefully. The State has reduced funding to public health by $150 million. There has been a $71 million reduction in the mental health services' funding.

We welcome the process that you are going through today. We think it is a a good opportunity for exchange of ideas.

I have been the health director for 3 years in Fresno County. I am responsible for public health, mental health and environmental health services. The choices I have made over the years have been painful, primarily because of the shrinking State and Federal health care resources that I rely on to meet the needs of the community.

We are experiencing expanding demands across the board. As one provider, we, Fresno County, and the health department in particular, are caught in the dilemma of not knowing from one year to the next what our funding level will be. We have seen funding levels continue to shrink. In 1983, the county began receiving funds from the Medically Indigent Adult Program, funded at a level of 70 cents on the dollar. Today it is probably closer to 40 to 45 cents. And this reduction was increased this year. Fresno County lost over $4 million in medically indigent services funding.

What we had to do as a result of the anticipated reductions was to look at the impact of reducing clinic services on the thousands of families who were dependent upon those services, and begin to plan for the elimination of the clinic services.

Your subject today, of course, is accessibility. We run five rural health clinics in the county. Since Fresno County is a county of 6,000 square miles, those clinics are indeed viewed as the access or the entry point to the health system. And if those were eliminated, and we seriously had to face that as a possibility, those impacted would end up in hospital emergency rooms and, as you know, would also not receive prenatal care, which that represents a significant portion of the services that we provide in those clinics.

One issue that we have dealt with recently in public health exemplies our problems. A few months ago I had to pull public health

nurses from their normal duties to cope with the worst communicable disease epidemic to hit this county in decades. We operate from an insufficient funding base, but, notwithstanding that base, we were forced to deal with about 50,000 children in this community in need of immunization. Only about 40 percent of those under the age of 5 have received their shots.

Mrs. BOXER. Are you talking about measles?

Mr. BLETH. Measles, yes.

In Fresno County in the last 5 years, we have jumped from 10 measles cases to over 456 in the first 6 months of this year. And, tragically, I have to tell you that 10 deaths from measles have occurred, all among Southeast Asian children.

Only through the door-to-door, one-to-one canvassing of Southeast Asian neighborhoods by the public health nurses were we able to avoid further misfortune. But while the effort was so critically needed, other folks in the county were unable to benefit from the services that the nurses normally give, or they were put on a waiting list for the next available nurse to help them.

As the administrator and the director of the department, I deplore the need for such choices like this. I think it represents rationing of the worst kind, particularly in emergencies.

As you are aware, a combination of State and Federal funds finances prenatal care for the low income. We need more help in this area. We had about 15,000 births in Fresno County last year. Fifty-five percent were born to mothers covered by Medi-Cal. Fifteen percent, over 2,000 babies, were born to teenagers. Over one-quarter of all new mothers lacked adequate prenatal care last year. It should not come as a surprise to you that Fresno County ranks second in this State in the number of low-birth-weight babies born in the most recent year for which we have data—1988. This is in spite of a comprehensive perinatal services program and an annual State and Federal allocation of about $57,000 for a prenatal care guidance program, specifically designed to outreach Medi-Cal eligible pregnant women, to encourage prenatal care.

It is really not enough to meet our target population, which is estimated at three and a half times higher than the current funding level.

Another point: Federal SLIAG funds have played a key role in the last few years, permitting eligible aliens to obtain medical care. This funding is due to expire in mid-1992. I would recommend that you promote its continuance beyond the sunset year.

Fresno County, with our many ethnic groups, has a special challenge. The Southeast Asian refugee community is growing, with over 40,000 Southeast Asians calling Fresno County their home. However, we are experiencing reductions in funding levels for social services and health care for this group, which will hinder this community, this group, from further integrating and accessing health care services.

We receive about $63,000 to screen new immigrants, for whom we conduct a health assessment and refer as needed to their primary physician. We are seeing that the system is stretched. We are not able to keep up with the increased demand, as much as we try.

We are also using Federal dollars to work with the Southeast Asian pregnant women who are hepatitis B carriers, to ensure that

their babies are treated at birth so that they do not become carriers.

I urge continued support and expansion of these fundamental methods of protecting the public from communicable disease. Again, our emphasis is on prevention.

Locally, to address the health needs of the Southeast Asian community, we have pulled together a task force of all the agencies which provise medical or social services to the Southeast Asian community so they may advise the department, advise the county, on what the health needs are. What are our resources? What do we need to do to address them? How can we better coordinate? While that forum is specifically dealing with health issues in general for Southeast Asians, they have also been very helpful for us in dealing specifically with the measles epidemic.

In that regard, a grant application from the health department is with the Office of Refugee Resettlement, for expansion of our Southeast Asian community health project. These funds will permit us to hire additional staff and to provide basic health education and nursing services. Again, it is to increase our immunization effort. And, yes, this is a plug for the grant application.

As the AIDS epidemic continues, we need to have aggressive Federal funding for both research, to eliminate the disease, and for treatment for those who are already afflicted. We have over 200 AIDS cases reported in Fresno County to date. We have an AIDS task force, to develop a comprehensive plan. We have involved the medical society and others in the community, again, to try to pull together the appropriate agencies and personnel to comprehensively plan. One of the needs that surfaces is the need for alternative sources to hospitalization for acute care, in particular, away from publicly funded facilities, which are already overcrowded.

Last, I think—and it goes along the line of what Mayor Humphrey indicated—that good health in America is a shared responsibility between all levels of government. One jurisdiction, be it the county or city or State or Federal, cannot independently prevent disease or otherwise assure good public health. Only by combining our resources and combining our talents can we, I think, ever achieve any progress and improvement in our overall health care system. So I would urge continued support of Federal programs that are aimed at prevention in a comprehensive fashion, and recognize that we are all partners in this endeavor.

I will be happy to respond to any specific questions you have, Congresswoman.

[The prepared statement of Mr. Bleth may be found at end of hearing.]

Mrs. Boxer. Thank you very much, Mr. Bleth. I do have a number of questions. I am going to hold them, however, until we hear from the panel, and I see that what was written on my sheet was wrong. And we have Salina Trevino from the Madera Family Health Center with us.

We welcome you, ask you to summarize your testimony in 5 to 8 minutes, and I will hold my questions until we hear from Dr. Telles.

STATEMENT OF SALINA TREVINO, FISCAL OFFICER, MADERA FAMILY HEALTH CENTER

Ms. TREVINO. Yes. I am Salina Trevino, the Fiscal Officer of Madera Family Health Center.

Madera Family Health Center is one of 600 federally funded not-for-profit health centers nationwide. Our target population is for the underserved. We all have ideas of what underserved means. It used to be for us farm workers and just migrants and now it we have added, plus those, Medi-Cal patients, refugees from Central America, from the wars, and the economic strifes in Mexico. Also common folks, those that do not have any insurance coverage and cannot afford health care.

We do not have access in the community because of financial limitations, pregnancies and deliveries for the economically under served are not available in our community, even those private patients. There is not enough OB's in our private sector in Madera to even see those.

And primary care, we have radiology and pharmacy that are still a problem to us. We have added to our facility, expanded our prepackaged pharmacy in order to help those patients that are given a prescription and do not go and fill it because they cannot afford it, so what we do is, we are expanding our pharmacy. We have also added sonography in house for our OB patients.

DENTAL

Not even those with Medi-Cal and CMSP have access in our community. Most dentists do not accept Medi-Cal patients because it is not cost effective for them. With our 95/210 Medicaid reimbursement program, we are doing a master plan right now to see if we can get our dental patients into it. With the 95/210 program, we can receive cost reimbursement for the dental program, whereas our private physicians do not have access to it.

We also have health education. At least 60 percent of our patients do not even have a high school education. They need the education so that they know how to administer their drugs and just learn about the basic health problems that they have. It is our philosophy, however, that they do as much for themselves as they can.

We have added to our own resources on our own. We have added two midlevel practitioners in the last 20 months on our own. We have received temporary funding as well as SLIAG and EAPC and with expanded access to primary care, we are hoping to add our dental and fill our client needs.

We need our Medicaid cost reimbursement to continue the 95/210 program. We do not feel our sliding-fee patients are going away. Health centers across the States are having the same problems we have. We have checked and compared notes with them. We feel we are doing an effective job and we need the Medicaid 95/210 program to continue.

And the last year, we have been growing at a 58 percent increase, our patient load. And our funding has not increased. We urge you for your support. Thank you.

Mrs. BOXER. Thank you very, very much for your testimony, and I will ask you a couple of questions.

Dr. Telles, you are a private physician, and we welcome you here today and look forward to getting your perspective.

STATEMENT OF JOHN G. TELLES, M.D., PRIVATE PHYSICIAN AND CARDIOLOGIST

Dr. TELLES. Thank you for inviting me.

I am a private physician and a cardiologist who has been in practice in the Fresno area for the last 11 years. But my experience, I have worked in county hospitals, VA hospitals. I have done attending rounds at the county hospital here. I practice currently on the north side of town, primarily at a hospital which has the highest private care percentage patients in the city of Fresno.

I think our hospital currently has probably 5 to 7 percent Medi-Cal patients compared to other facilities in the area which have anywhere from 70 to 40 percent Medi-Cal.

Mrs. BOXER. Say those numbers again. What percentage Medi-Cal?

Dr. TELLES. St. Agnes, it is probably about 7 percent currently versus—I think there are other hospitals which will be presenting today. I know Valley Children's Hospital has a Medi-Cal percentage up in the range of 60 to 70 percent. Fresno Community probably in the range of 40 to 50 percent. Those are kind of broad numbers and they will probably be elaborated on later on.

What I would like to make some comments on is what I see as decreasing access to health care in the private sector by patients, and primarily I am going to talk about not the uninsured patient, because I think he is not even reaching the private hospital. But primarily the Medi-Cal patient, some of them do reach private hospitals.

What I have experienced in my practice in Fresno over the last 10 years of my Medi-Cal referrals, I see referrals primarily from other physicians, primarily internists and family practitioners. My Medi-Cal referrals, primarily Medi-Cal has decreased from 15 to probably less than 1 percent now.

I see the reason for that not so much the cost reimbursement, but more the bureaucracy. And I will talk about that as we go along here.

But I think my experience is kind of a barometer of what is happening with the primary care physician in our community, because I see the patients that they see, and I see primarily patients from a young physician referral population, physicians who you would expect new in practice that would have a relatively high Medi-Cal load. But they really do not.

The reason why I think they do not is, as I mentioned, Medi-Cal is extremely low reimbursement, and also the onerous bureaucracy.

I am going to give you some examples. I am sure physicians in your district have talked to you about these type of problems, but, for the record, obstetrics. In our hospital, I think there are only one or two physicians who do obstetrics who will see Medi-Cal patients on an elective basis. And I think the reason for that is primarily——

Mrs. BOXER. What was that again?

Dr. TELLES. There are one or two physicians in our hospital's obstetrics department who will see Medi-Cal patients on an elective basis out of probably about 25 OB physicians there.

And the reason for that is somewhat bureaucracy, but also the reimbursement. For a Medi-Cal physician who sees primarily just Medi-Cal, doing deliveries at the present reimbursement rate, he would have to see probably in the range of 500 to 600 deliveries per year to make a salary which would be similar to your salary, which would be a patient load that would be impossible.

Another example is the way some procedures are reimbursed with Medi-Cal. I remember in particular a patient who I was caring for because of a cardiac problem who also had rheumatoid arthritis and who needed gold shots. I could find no rheumatologist in our community who would see the patient because he was Medi-Cal. So I figured I would just go ahead and give the gold shots myself out of my specialty, but I knew enough about it to know what to do. I did go ahead and give the gold shot and we got the check from Medi-Cal for reimbursement and that was 87 cents, which the gold shot itself cost about $15. The application—I figured the expense was about $25. So it is very obvious to me why a rheumatologist in Fresno was not going to see a Medi-Cal patient.

One other problem that the primary care physician has is that the current level of reimbursement for a routine 15-minute office visit is about $8 to $12. The primary care physicians' overhead in our area is anywhere from $50 to $75 per hour. Obviously if you see Medi-Cal patients, you are going to have to be subsidized someplace because you just cannot afford to do it as a physician.

I could go on and on with examples on the reimbursement issue but I think these are things you have heard before and you are aware of them.

One thing of which I think we have an opportunity in Fresno to really experience what happened with the change in bureaucracy. Fresno County, about 7 years ago, had an unusual Medi-Cal system in that every Medi-Cal claim was reviewed at the Medical Society. I am the immediate past president of the Medical Society so I have quite a bit of understanding of how this process worked. But that process involved a lot of physicians in the community in the case of Medi-Cal patients. What we would do is review every Medi-Cal claim, make a judgment of whether this is appropriate care and whether the claim should be paid. It accomplished two things. It kept private physicians in the Medical treatment arm and it also prevented any development of what you have probably heard as Medical mills.

I would say eight years ago the fraud and abuse of Medi-Cal in Fresno County is probably much less than what is occurring currently and this is primarily because of a change on what has happened, in the way Medi-Cal is organized here.

The reason why the change occurred was because the state no longer would fund that program at a level where it would be viable to maintain at the medical society.

Another example of the onerous bureaucracy is these things which we call TARs. These little things here. Have you ever seen one?

Mrs. BOXER. No.

Dr. TELLES. This is a form you fill out to get a treatment authorization request to get approval to do treatment on a patient for almost any procedure. An example would be if I wanted to do a heart catherization on a patient because I felt that they had enough disease which would merit further evaluation, I would fill this out, send it to the Medi-Cal office and then wait. We are told this should be rather prompt and turned back to us in 1 or 2 weeks. My experience is it usually comes back three or four weeks. It usually comes back with a denial that the form was filled out wrong. You submit the same form in and you eventually get an approval maybe 6 weeks later——

Mrs. BOXER. It is an approval for what type of procedure?

Dr. TELLES. In my specialty, for heart catherization, for coronary bypass surgery, for——

Mrs. BOXER. And I guess that is because they have found that many doctors were doing unnecessary bypasses——

Dr. TELLES. Well, I am not sure that they actually found that. I think that that is a suspicion. But I——

Mrs. BOXER. Well, I think there were studies at the Federal level that did confirm that there were unnecessary surgeries so I assume that this is a way to make sure that that is necessary. But you do not believe. You believe——

Dr. TELLES. No, I do not

Mrs. BOXER. You believe it is a way that they are using to deny these——

Dr. TELLES. I think it is a way to indirectly control the costs of the Medi-Cal system by slowing the degree of services, and in a sense, decreasing the access of Medi-Cal patient to those services by making the wait so long that eventually everybody forgets and something happens. Either the patient dies or something like that.

And I do have examples of many patients who have been waiting for their heart catherization who develop an unstable condition and then have to be admitted to the hospital on an emergency basis, costing the whole system much more than it would have if we just could have taken care of it on an elective basis.

Mrs. BOXER. How many examples do you have of that? I would be very interested.

Dr. TELLES. Three or four in the last couple of years.

Mrs. BOXER. I would be interested in——

Dr. TELLES. And I could give you the names and specifics.

Mrs. BOXER. Thank you. I would appreciate that.

Dr. TELLES. What I was alluding to before. This type of authorization was done locally through the medical society and it was done very quickly, promptly, and correctly. And it was a system that worked, prevented fraud in our area.

And I have an example of a patient that I saw a few months ago. This is his bill from a walk-in clinic that I will not give you the specifics here for reasons of privacy, but this patient had probably, from just adding things up, I would estimate probably $20,000 to $30,000 worth of procedures done, somewhat probably inappropriately with, I do not know who is watching this or if the TAR system is really effective in cutting that out.

Mrs. BOXER. I want you to explain that a little more. You are saying this particular patient who is on Medi-Cal had unnecessary procedures done, by whom?

Dr. TELLES. I cannot say that right now.

Mrs. BOXER. No. But was it by a private physician?

Dr. TELLES. Yes.

Mrs. BOXER. And did they send in the forms?

Dr. TELLES. I assume. I assume they have to send in the forms. They have to be approved by this process. You know, it will eventually be approved and you can do anything, it just takes a long time to get it approved. I have never had one denied, by the way. Never.

Mrs. BOXER. I see. The point is that the decision is being made too far away from the circumstances——

Dr. TELLES. Yes. It is too far away and it is——

Mrs. BOXER. Where is the office that you need to deal with?

Dr. TELLES. You deal with the—initially I think with the local Medi-Cal field office and then eventually you end up talking to the State. It is something that whenever I do this, my secretary does it full time because it is something I do not have time to get involved in.

Mrs. BOXER. I am going to ask you to wrap up in just a few minutes.

Dr. TELLES. One other thing on bureaucracy. Do you know what this is? Have you ever seen this, Congresswoman?

Mrs. BOXER. No, I have not.

Dr. TELLES. This is the Medical Provider Handbook that tells you how to bill for a Medi-Cal claim. It is about 750 pages.

Mrs. BOXER. And who puts it out?

Dr. TELLES. The Medical Field Office.

Mrs. BOXER. In State.

Dr. TELLES. The State. But obviously if you have a 750-page book to do billing with, the system is just so onerous as far as bureaucracy goes that most physicians would not want to deal with it.

And what has happened here, especially in the north side of our community, is not so much because of reimbursement, because the reimbursement rates are not that much different than they were 10 years ago, but what changed primarily was the way the system was done. We had this local program, as I mentioned before. The local program was terminated. The physicians became aware of the true bureaucracy in the Medi-Cal system and the Medicaid system and gradually began dropping out. And as a result, at least in my experience, my Medi-Cal practice has decreased from 15 to less than 1 percent.

I could say a lot of other things too but I think that would basically summarize it.

Mrs. BOXER. I think you make your points very clearly. I am going to ask some questions if I could.

Mr. Bleth, I really admire the task that you have. You run the whole show as far as health is concerned, even environmental protection for the county and public health and mental health, all under your supervision. How many people work in your department?

Mr. BLETH. About 800.

Mrs. BOXER. How would you describe our health care system today? I mean there was a time when I was on the Board of Supervisors in Marin County, which goes way back about 14 years ago, that the word was, "Let's not have a two-tier system." Or "Let's have access for everybody." And now I am thinking of it more as a three-tier system which is the good system, if you can afford it, and if you have adequate insurance. And then the less good system, if you are lucky enough to have any type of insurance. And then no system. Is that where we are today, do you think?

Mr. BLETH. I think that is an accurate description. I think those individuals in the community that we serve, if they have reimbursement, usually go through the bureaucratic process to which Dr. Telles has referred. Those that do not have a revenue source, end up at the doorstep of the county.

Bruce Satzger, our County Hospital Administrator, is here and can address that issue. But I deal with the uninsured at the clinic level, where we do not turn people away. The general taxpayer subsidizes that care.

Mrs. BOXER. If a doctor refuses to take Medi-Cal, for some of the reasons Dr. Telles said, and they just do not do it, they do not want to do it, they cannot afford it and they do not want to be bothered with 750 pages of regulation, where do these people go?

Mr. BLETH. They end up at the county doorstep.

Mrs. BOXER. And what do you tell them? Do you take their Medi-Cal?

Mr. BLETH. We take the Medi-Cal. That is one of the primary revenue sources for the health department on the public health side of the house.

Mrs. BOXER. Do you agree with Dr. Telles in his criticism of the program?

Mr. BLETH. I think we have to recognize that the Medi-Cal system does not pay for the cost of care. I think the bureaucracy, the paperwork, is cumbersome. It is hard to deal with, even from another bureaucracy's perspective. But it is an important revenue source and the county has to rely on it.

Mrs. BOXER. Right; I understand. But you would agree with his critique of the system?

Mr. BLETH. I think the bureaucracy is cumbersome, yes.

Mrs. BOXER. And if, in fact, it worked better, and doctors, like Dr. Telles, took these patients, you would have less of a burden, is that accurate?

Mr. BLETH. That is accurate. Our concern is that there are fewer and fewer providers seeing Medi-Cal patients, for those reasons, and, as a result, they are in one of the clinics that you represent or that the county represents.

Mrs. BOXER. So that you do not only have to deal with the completely uninsured people, you have to deal with the Medi-Cal people?

Mr. BLETH. Yes.

Mrs. BOXER. You get the double——

Mr. BLETH. Primarily, yes.

Mrs. BOXER. In terms of measles, I am very interested in this because I was the Member of Congress who wrote and freed up some

of the funding for new infusion into that immunization program. Did you get some more funding from the Federal Government?

Mr. BLETH. We got more in the way of vaccine.

Mrs. BOXER. Good; that's what I mean.

Mr. BLETH. Yes.

Mrs. BOXER. You did get the vaccine?

Mr. BLETH. We got more doses.

Mrs. BOXER. Good.

Mr. BLETH. What we are seeing is that there is just a whole lot of public education outreach that has to occur. We have so many kids in this community who are not being immunizes, even though we are providing free immunization. I do not think it is the vaccine that is an issue right now for us. What is at issue are the resources to hire additional public health nurses. We have not hired new public health nurses in years.

Mrs. BOXER. So essentially it would be very helpful if the grant from the Immunization Program from the Federal Government not only gave you the vaccine but gave you some personnel?

Mr. BLETH. Yes; that is one of the reasons we applied for the refugee funding.

Mrs. BOXER. And I can assure you that Congressman Lehman and Congressman Condit are pushing hard for that. And I will certainly work with them to help add my voice to that effort.

Mr. BLETH. That would be appreciated.

Mrs. BOXER. I have a couple of other questions for you.

I want to go over some of these numbers because I think they are really astounding. You are saying that in Fresno County there were 15,000 births last year and 15 percent of those births were to teenagers.

Mr. BLETH. Yes; we have a higher teenager pregnancy rate in this county.

Mrs. BOXER. Do you have a family planning program that you operate out of your county?

Mr. BLETH. Yes. As you know, the State went through a reduction a year ago. The State legislature eventually restored the funding. We never curtailed the county's family planning program. We have that. We also work with the Economic Opportunity Commission, which also has a family planning activity, as well as Planned Parenthood.

There is also a teenage pregnancy program operated in conjunction with the Department of Social Services, Valley Medi-Cal Center and our shop to address that issue.

Mrs. BOXER. Sure I have got this right—of the 15,000 births, one-quarter of the women had no prenatal care whatsoever?

Mr. BLETH. That is our estimate, yes.

Mrs. BOXER. And that 55 percent of the mothers of those 15,000 births were on medicaid?

Mr. BLETH. Medi-Cal.

Mrs. BOXER. Medi-Cal.

Mr. BLETH. Yes.

Mrs. BOXER. I would have to say that Fresno County has got some very serious problems that reflect what is happening in the country, but to me these numbers, I read about them in all of our information that comes nationwide, but I see reflected in this

county some of the most serious problems we are facing. Low-birth weight babies and an infant mortality rate that I am not sure—can you give us a little light on that? How do you do on infant mortality?

Mr. BLETH. Not good. I do not have the numbers, but I can provide them.

Mrs. BOXER. I would like to have them for the record, because we are 20th in the world among nations in our infant mortality rate because we are not doing prenatal care. And when you look at the priorities of this country, and listen to people, we could do it easily.

Mr. BLETH. I know it is particularly high in the black community in Fresno. We have put together a couple of grant proposals and we have been working with the state to try to get some funding to address that issue, but I can provide you with the specifics on the Fresno County experience.

Mrs. BOXER. Just a couple of other things. How many AIDS cases have you had here since the epidemic started?

Mr. BLETH. Close to 200 reported cases.

Mrs. BOXER. 200 cases of AIDS? And do you have any notion about how many people are HIV positive?

Mr. BLETH. As you know, it is not reportable or required to be reported. It is one of those areas that——

Mrs. BOXER. Have you extrapolated from the 200 what you think——

Mr. BLETH. Well, it could be several thousand or several times that figure. It is a crystal ball, I think, at this point. What we are trying to do is address it through the AIDS Task Force, by putting together a countywide plan to address the potential for AIDS cases.

Mrs. BOXER. Are you getting the funding from the Federal level that we have pushed so hard for in our Committee? We have greatly increased the funding in the hopes it would get to you. Have you gotten some grants on that?

Mr. BLETH. We have Federal AZT funding. But we have reductions in funding at the State level, as they shift dollars to other counties. We are going toward a State subvention process, eliminating the categorical State funding in favor of block grant type funding.

Mrs. BOXER. So most of the funding is coming through the State—from the Fed through the State to you.

Mr. BLETH. Yes.

Mrs. BOXER. Well, I really want to thank you. You really are on the front lines. It is very helpful to me and to my colleagues who will read this and will discuss this with me.

Ms. Trevino, I want to talk about a couple of things that concern me. You said that 60 percent of the people that you see in your clinic have had no high school, is that what you said?

Ms. TREVINO. Yes; 60 percent of them do not have high school education.

Mrs. BOXER. So you are dealing in your clinic with the whole education system as well as health care?

Ms. TREVINO. Yes.

Mrs. BOXER. How many patients do you see?

Ms. TREVINO. Last year we saw about 22,000.

Mrs. BOXER. And what is your staff ratio? How many staff people do you have?

Ms. TREVINO. We have a total staff, including administrative, close to 40 people.

Mrs. BOXER. And you see 22,000 people. And you do all kinds of care?

Ms. TREVINO. Yes.

Mrs. BOXER. Everything?

Ms. TREVINO. We also have an AIDS program. We also have health education—we have a tobacco program too that we do.

Mrs. BOXER. That is good.

Ms. TREVINO. We have all areas. We want to start dental as well.

Mrs. BOXER. And the county that gives you most of your funds?

Ms. TREVINO. Most of our funds come from the State.

Mrs. BOXER. Directly to you from the State.

Ms. TREVINO. From the State. And we do have a Federal grant, 329 and 335 for migrant and community health.

Mrs. BOXER. And you say you use a sliding scale. So depending on the person's ability to pay, they pay. But what percentage actually pays more than Medi-Cal? Is it small?

Ms. TREVINO. It is small. I do not have the numbers in here.

Mrs. BOXER. In your own words, how would you describe the state of health care in Fresno County for the people that you see? Their access, their ability to get it, their state of health?

Ms. TREVINO. Access is the No. 1 researching now trying to get the patients to come to our health center. A lot of them walk. And a lot of them are pregnant and cannot come. So Madera County does not have a really good public transportation system. We want to contract with a "Dial a Ride" system so that we can get the patients that live out in the country areas to come in. A lot of them need the education also to learn about what is wrong with them.

We have language barriers and economic barriers too. They do get a chance to apply for our sliding scale and we encourage them also to apply for Medi-Cal. Medi-Cal is one of our biggest funding or 60 percent of our income.

Mrs. BOXER. Thank you very much.

Dr. Telles, do you see Medicare patients?

Dr. TELLES. Yes, I do.

Mrs. BOXER. How do you compare those programs in terms of the bureaucracy and the funding reimbursements?

Dr. TELLES. Well, Medicare is certainly much better than Medi-Cal as far as funding reimbursement, but still there are problems arising there, as you are aware. And there are problems which are built into the present Medicare system which are kind of geared to limit access. And examples of that would be one of the—you are familiar with the DRG reimbursement system?

Mrs. BOXER. Yes.

Dr. TELLES. You know, if a patient is in a rural hospital in our area and has been there for a week or so and has to be transferred to a tertiary hospital with a little more horsepower in the medical center, one of the problems there is that there is a tremendous discouragement to transfer that patient because his DRG was used up at the preceding hospital. So we have not really encountered problems like that here in Fresno, but it is a potential problem which

will limit the access of the rural patient to the tertiary referral center.

Mrs. BOXER. Let me ask you a question because your testimony was very disturbing in terms of the Medi-Cal system even being able to in any way get any private physicians to participate in the system, unless they wanted to do charity work as a percentage of their practice.

So my question to you is, Do we need to look at a whole new way of servicing indigent people——

Dr. TELLES. I think so.

Mrs. BOXER [continuing]. And if so, what should that be? Should it be a way in which everyone has a national health insurance policy that they can use? Or should it be in a way where instead of having indigent people go to private physicians, they go to clinics that are funded by the Government and salaries paid to physicians, and their job is to see indigent patients? What do you see as a remedy?

Dr. TELLES. I have a lot of suggestions. My first suggestion would be to totally reform the Medicare system. One reason why I am somewhat disturbed by the Medi-Cal system is because the system treats the physician as a criminal. That seems to be the premise of the review processes that are incorporated in the Medi-Cal system that the physician is first a criminal who is going to ripoff the Medi-Cal system. And actually it is my contention that the way the system is currently designed it will generate criminals. It will generate people who the only way they can survive under Medi-Cal is to do high volume, perhaps poor quality care. And there are lots of examples of that up and down the State of California.

I think the biggest examples are the abortion clinics. I am not going to mention anything about pros or cons on abortion, but there are abortion clinics in Los Angeles which have million dollar advertising budgets. And this is primarily to attract a Medicare patient. As you know, in California, Medi-Cal reimburses for abortion, and there is no need for parental approval and all that, and if you look at the statistics in California, there is no—the abortion clinics are doing abortions on folks which have had lots of other abortions. There is a high percentage of repeated——

Mrs. BOXER. Wait, let us get to the point. I am asking you how can one have a situation—you have already stated that you think it is a problem.

Dr. TELLES. Yes.

Mrs. BOXER. And I am saying, assuming you are correct, that in fact the Medi-Cal system is not working because you are not getting enough money and it is too bureaucratic. Is the answer to get you more money and make it less bureaucratic or is the answer to forget working with the private sector physicians——

Dr. TELLES. No, I think the first thing to do is make it less bureaucratic. And I mentioned the program that we had in Fresno here 8 years ago.

Mrs. BOXER. And you support a return to that?

Dr. TELLES. I think it is a great program. It should be reinstituted not only here but in all localities where the control is local rather than at a State level or a Federal level and that is going to be a great step in reducing the bureaucracy in that.

And making the whole reimbursement process more simple. You do not need a 750-page book. We deal with other insurance companies and our documentation booklets are less than 10 pages. There are a lot of areas that can be trimmed.

Mrs. BOXER. So you would like to go back to the way it was?

Dr. TELLES. The way it was in Fresno County.

Mrs. BOXER. Yes.

Dr. TELLES. This is something that I do not think——

Mrs. BOXER. The way it was in Fresno County.

Dr. TELLES. Yes. I do not think you totally understand this, because this was a pilot project that was only in Fresno County. It did not exist in the rest of California.

But it really served the purpose in integrating the Medi-Cal patient into the private sector. And the private sector is willing to take care of a percentage of Medi-Cal. Even if the reimbursement level is at a level that it does not cover cost. I think the private sector—many physicians, my colleagues, are willing to see a patient in a sense on a charity basis, that is no problem. Just do not burden us with the bureaucracy that goes along with it.

Mrs. BOXER. I understand your point. Thank you.

A VOICE FROM AUDIENCE. I represent Channel 21 and I have a couple of questions I would like to ask if you do not mind.

Mrs. BOXER. We will not be able to—we will have to take a break after the next panel and do that, if you can wait, because I——

A VOICE FROM AUDIENCE. About an hour?

Mrs. BOXER. Yes, I would say. About 30 minutes. Yes, Mr. Bleth.

Mr. BLETH. You are here looking for ideas about how access is being dealt with, and I think what I would like to share with you is one access, and Dr. Telles touched on it, and that is the access of the patient in the rural areas getting care in the urban areas. And what prompted my thought is that one of the television stations showed a program—48 Hours—the other day where a patient languished in a rural hospital for 28 days and could not get transferred to one of the urban hospitals where there was an appropriate level of care. That patient died. We also have been dealing with patient transfers.

I am also the director of the EMS agency. One of the ways we use the CHIP money, the Proposition 99 cigarette tax money—in working with the local hospitals—is to set aside a pot of money as a risk pool to be available to those hospitals who agree to accept transfers of those patients in the rural areas where they do not have the medical expertise to care for the patient. Out of that pool those hospitals will be reimbursed for patients who are indigent and who cannot get into the county's hospital. It has not been done before in this county, to my knowledge. The private hospitals have heretofore been reluctant, of course, to accept nonpaying patients. To me it represents a creative way of using those dollars in cooperation with the local hospitals.

Mrs. BOXER. That is very interesting.

Mr. BLETH. So it is improved access to care, a very, very critical area, and I thought I would share that with you because it is a need that we have had and it is a unique way of using the cigarette tax dollars.

Mrs. BOXER. Thank you very much.

I want to thank this first panel. You have been terrific and really have given me some information I did not have before and certainly in your description of this county I see here a reflection of the national problems. And I will take the information back. Thank you very much.

We will call the next panel. Dr. Northway, president and chief executive officer of the Valley Children's Hospital; Tony Vang of Lao Family Community of Fresno; and Anna Phillips, director, Health Services, Fresno Unified School District.

We would like to start right in with Dr. Northway, and if you could try to summarize in about 8 minutes. As you see, I have a lot of questions.

STATEMENT OF J. D. NORTHWAY, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, VALLEY CHILDREN'S HOSPITAL

Dr. NORTHWAY. Chairwoman Boxer, thank you very much for coming to Fresno and we welcome you to our community, and thank you for allowing me the privilege of sharing some observations which I have on the cost of health care and its accessibility as it pertains to America's children.

Besides being the president and chief executive officer of the only private free-standing children's hospital in rural America, I am also a pediatrician. So I think that I understand some of the clinical as well as the business aspects of the problems arising from our present health care delivery system for children.

Let me tell you a little bit about the mission of Valley Children's Hospital, and it is to provide access to comprehensive pediatric services to more than 700,000 children living in the central San Joaquin Valley regardless of their ability to pay. And I think that you have heard a lot already this morning about the ability to pay. The Children's Hospital has not closed its doors regardless of the family's ability to pay.

For 38 years we have lived with this mission, but I will have to tell you over the last couple of years it has been tough sledding. And in particular, the last 4 months of this year we have already lost $1.4 million because our expenses exceeded revenues.

I emphasize these losses did not occur because we had empty beds. They occurred quite to the contrary. It is because the reimbursement covered by the Medicaid system just fell short of covering the cost of care.

What things have led to this point where actually now we are in the situation where financially we are having trouble serving the people we really want to serve. And I think you have heard some of the reasons. As other agencies are running out of money, and so they are turning to the court of last resort, if you will, for children, and I think that is the Valley Children's Hospital in Fresno.

We are a very fast growing county in California, about 4 percent a year, but unfortunately a significantly large percentage of the families coming in to Fresno either lack education or lack economic resources. For the first time I think, Congresswoman Boxer, in our history, we are seeing the poor leaving urban America and coming to rural America where it is a little bit less expensive to live on the same amount of dollars that you would get in an urban setting.

Now, as this growth continues, the frightening thing to us is that we anticipate by 1995 that approximately 50 percent of all the children living in the central valley will be on medicaid. And with each passing year, literally each passing month, the numbers of Medi-Cal dependent patients treated at Valley Children's Hospital has risen. Our Medi-Cal census now averages over 70 percent. We are the largest Medi-Cal provider, pediatric provider, in the State of California, and probably the largest medicaid provider for children in the United States.

You would think that a hospital that is overflowing and in some cases having to turn patients away because there are no beds that we would not be facing financial problems. But Medicaid, or Medi-Cal in this State, pays Valley Children's Hospital only about 85 cents for every dollar of health care delivered to the Medicare patients. Well, with over 70 percent of the patients on one insurance policy, we do not have very many patients left that we can shift the shortfall onto. And as a result, we have begun to lose money.

Well, why are so many of these children ending up at our doorstep? Poverty is certainly part of the problem and we see that across the country. That is not unique to this area. But cultural differences I think are another real problem.

And let us talk a little bit about our Southeast Asian friends who have come and have become an important part of our community. We have about 29,000 Mongs in our population, and this group is growing, and I am sure Mr. Vang will talk about this. These peoples' ideas about health care are vastly different from ours, and at times leads to some serious problems for us in the health care interacting with this group of people, but through folks like Mr. Vang, we have been able to overcome a lot of these problems.

And let us talk a little bit about the recent measles epidemic which hit the Mong community extremely hard. And why, in part, were some of these children not immunized? Some of the reasons have to do with the religious beliefs of the Mongs. And, for example, it is my understanding that they really do not like to have—none of us do—but for religious reasons they do not like to have the skin punctured, because there is an idea that maybe the soul would leave the body in that regard. You have to puncture the skin in order to immunize somebody against the measles.

But we try to respect their religious beliefs, because they are as important to them as ours are to ourselves, but it puts us into a difficult situation at times. We are often thwarted in our ability to draw blood, to do spinal taps or even to administer shots. And, of course, without immunizations, these children have no inherent resistance to the measles virus and so they came down with the illness.

In addition to that, once the child came down with measles or was exposed to measles, because of their concern about what might happen if they went to the hospital, they tried to continue to care for the child in their own environment and when that finally did not work, then they would come to the hospital extremely ill and, as you have heard, we have had 10 deaths which represented 25 percent of all the deaths in California from measles.

Although the situation in the Southeast Asian community is one situation, and it is maybe related to the problem somewhat to their

particular religious beliefs, there are many barriers that are shared by the majority of the low- income Government dependent families in securing health care. Many of our families cannot take their children to the doctor because they lack transportation. Or someone to care for the other children in the family when they do come to see a physician. So they wait until the child is just critically ill, beyond their ability to manage the care, and then they turn to us but usually it amounts to a hospitalization and an expensive hospitalization.

Others may not have a primary care physician, as you have heard Dr. Telles mention, although I will have to say in the pediatric community of Fresno County, the pediatricians have really been role models, as has the family practitioners, in taking care of Medicare patients. But if they do not, then they have no one to turn to except the emergency room, and that is a really very poor and expensive way to get any kind of medical care.

But the real tragedy in some of the communities around is that the families do have the knowledge to access the health care system but they do not have the means. They earn too much money to qualify for Medicare and their job sources do not provide health care benefits or pay enough—the job does not pay enough—to allow the family to purchase their own health insurance. A real tragedy in this country. And you talked about the uninsured, and it certainly affects children in this country as well.

So how do we make basic health care accessible to all of our children? I think there are two main issues. You probably know them and are sort of nauseated by hearing them, but let me repeat them again.

I believe that eligibility criteria for these programs, for the poor in our country, must be standardized nationwide. And they must be comprehensive enough to include the children who are really at risk. And, second, reimbursement for services must cover the real cost of providing these services. So the eligibility has got to be there, and the reimbursement has got to be there or otherwise the patient is denied access.

Presently, as you know, eligibility requirements vary greatly from State to State. California happens to be a pretty good reimbursement State. But in many other States, children are excluded because of the eligibility requirements.

And then, of course, the medicaid system usually does not pay costs and it certainly does not pay costs in California. We have provided $28 million in unpaid-for care for the children living in our Valley last year and this year it is going to be over $30 million. I can tell you that not many businesses can remain viable with writeoffs of that magnitude year after year.

In closing, let me offer some personal observations I have made this past year as a member of the National Commission on Children. I have traveled across this country listening to parents, teachers, counselors, social workers, health care providers, and I want to tell you that if we do not find solutions, if solutions are not found in regards to the problems facing our youngsters, as a country we are headed for disaster.

Many parents realize that they are not able to promise their children a better life than they have had. That has never happened

before in this country. We have always said to our kids, "Life will be better for you." We cannot say that now. There are more and more parents, people in our country, who have given up because the chances of making it out of poverty are just not possible.

I believe that we do have the ability to turn things around for this and future generations. And our first step that we can take is making access to health care an absolute right for all children by designing realistic and standardized eligibility requirements and by reimbursing health care providers at a rate which encourages them to take care of children who live in poverty.

Thanks very much. I will be happy to answer any questions you might have.

[The prepared statement of Dr. Northway may be found at end of hearing.]

Mrs. BOXER. I really appreciate your terrific testimony and I will be back to you with a question or two. Mr. Vang, welcome.

STATEMENT OF TONY VANG, EXECUTIVE DIRECTOR, LAO FAMILY COMMUNITY OF FRESNO, INC.

Mr. VANG. Thank you. Good morning, Congresswoman Boxer. My name is Tony Vang. I am the executive director of Lao Family Community of Fresno, a nonprofit organization that serves refugees and immigrants.

I am here today to speak on behalf of the Southeast Asian refugees in the community of Fresno. Therefore, the health care needs and recommendations that were addressed are specific to this population with an emphasis on children.

The Southeast Asian population includes political refugees and immigrants from Laos, Vietnam, and Cambodia. As you know, the political refugees are here as a result of the Vietnam war. Although the differences from one group to another in general health care beliefs of Southeast Asia do not correspond to those of Western medicine. For Americans and for Southeast Asians, unfamiliar healing techniques foster mistrust on both sides. Southeast Asians rely on traditional healing practices such as ancestral worship, herbalism, and acupuncture, practices that are often in conflict with Western medicine and its emphasis on science and germ theory. On the other hand, Western health care practice often alienates patients from Southeast Asians, resulting in what Western providers consider to be noncompliance with medical advice.

The lack of trust escalated when one Western care provider called child protective services to force medical compliance. In some instances, the lack of trust and the refusal of such a patient to accept medical advice and treatment has resulted in premature death and disability of women of childbearing age of children.

For example, because of lack of understanding and fear of surgery, a young Mong woman died in childbirth rather than agree to a cesarean sector. Another graphic and tragic illustration of increasing mistrust, miscommunication, and lack of health care education is the risk of measles in Fresno County which took the life of 10 Mong children.

Word of mouth plays an important role for people who may not be literate in their own languages. Negative, misinterpreted, often

erroneous information on how patients are treated and why they receive certain kind of treatment spreads quickly through the community, not only here in Fresno, but wherever refugees reside in the United States and in refugee camps overseas.

The results in the health care problems facing Fresno County, we must address both overall relationships between physicians, patients, as well as the crisis such as the state of prenatal and delivery care as well as what our community experienced during the measles crisis.

There has to be continued education for both Southeast Asian and for health care providers to improve utilization of decent services. The health promotion project at Lao Family Community has provided education on basic health information, hygiene and safety for Mong, Laotian, Cambodian, and Vietnamese refugees for the last 5 years. It reached 46,000 refugees, speaking four major languages. However, current funding and funding in staff allocation are inadequate.

Second, we must build a partnership between community representatives and health care providers in partnership including those in direct service.

The recent effort on the part of the Fresno County Health Department to forge such a partnership is a positive step towards this goal.

Third, we must increase the number of bilingual biculture health care professionals. The number of trained interpreters and professionals serving the community in assisting in breaching the communication gap is inadequate. Until we have trained professionals among the Southeast Asian community, individuals will continue to receive inadequate services.

Four, any effort must involve the community leaders, communicating with and through the leadership with health care information to a far greater number than the conventional methods. By taking these proactive steps in improving health care, Fresno will be much better prepared to deal with any crisis as it arises.

I would like to make some recommendations as the following. One, increase and guarantee continued funding for trained interpreters in professional positions in the health care and social work.

Two, provide funding for increased training opportunities for minorities in health and social service positions, including LVN, RN, and social workers.

Three, continued funding of programs that address basic community health and education needs in culturally sensitive language and appropriate methods.

Four, address ways to increase the poor Medicare providers and reassess Medicare guidelines that limit health care treatment. Many refugees depend on welfare assistance, specifically Medicare, for health care needs. There are a limited number of physicians who take Medicare patients, resulting in less availability in access to health care. Thank you.

[The prepared statement of Mr. Vang may be found at end of hearing.]

Mrs. BOXER. Thank you, Mr. Vang. Ms. Phillips.

STATEMENT OF ANNA PHILLIPS, DIRECTOR, HEALTH SERVICES, FRESNO UNIFIED SCHOOL DISTRICT

Ms. PHILLIPS. Thank you. I am going to be addressing one aspect of the health care crisis, and that one aspect is teenage pregnancy.

As director of health services for Fresno Unified School District, a district that serves approximately 68,000 students, I am well aware of the impact of teenage pregnancy as a significant health problem.

In our school district, girls who are known to be pregnant or suspected to be pregnant are referred to the school nurses. In 1986–87 we decided to start compiling data on teenage pregnancy, not having had any hard data before and needing to be able to report on the situation. That first year in 1986–87, the nurses reported 454 known pregnancies. One was 12 years of age; 5 were 13; 23 were 14; and 91 were 15, et cetera. Each year we have had one or two girls who have been in the sixth grade that are 12 years old and are pregnant. We continue to see 13-year-olds, 14-year-olds, et cetera. The biggest number are 16-year-olds.

In our statistics, we find the greatest number of pregnant students in our school district are Hispanic. In 1987–88, the nurses reported 552 pregnancies, 67 second pregnancies and 11 third pregnancies. The year before we had 31 second pregnancies and two third pregnancies. So each year the number of second and third pregnancies have increased.

In 1988–89, 554 pregnancies were reported, 73 second pregnancies and 13 third pregnancies.

In 1989–90, the statistics from last year, are not completed at this point, but as a subtotal, we are seeing 562 pregnancies, 72 second and 16 third pregnancies.

When we look in our school district at the numbers of significant health problems, for example, asthma, diabetes, seizure disorders, orthopedic problems, et cetera, and if you reduce the population by half, eliminating males, we see teenage pregnancy second only to asthma and allergies in the number of students affected. So it is a major health risk for our students.

Setting numbers aside and giving consideration to the impact of pregnancy on the health of the teenager and the infant, we see how devastating this problem can be. I think very often when we hear statistics we do not hear what happens to the girls and what happens to their babies.

I am going to depart just a little bit from my printed presentation. And I want to share with you for one year the comments and information provided by school nurses that I compiled for one school year. One health problem experienced by pregnant adolescents, preeclampsia toxemia. Ten students. One was hospitalized for one week. Another one was hospitalized for two weeks after delivery due to persistent high blood pressure. Fifteen students had Caesarian sections. Eight students were followed for vaginal bleeding. One child, or one student, was hospitalized for three days. Ten students were followed with premature contractions. One was hospitalized for five days. Thirty-eight students had therapeutic abortions that the nurses know about as they were reported to them. One of them was due to severe birth defects. One therapeutic abor-

tion was self-induced. One was due to herpes. One child who had an abortion reported it was her third pregnancy. She had a 1½-year-old and she had a 6-month-old at home. One student returned to the hospital by ambulance 2 days after her abortion due to severe bleeding and she was also experiencing problems with urinary incontinence.

Sixteen students had spontaneous abortions. One student was very depressed following her second spontaneous abortion and needed treatment. One was her third pregnancy, which had followed two spontaneous abortions prior to that.

Students experienced different infectious problems during their pregnancy. One had hepatitis diagnosed at delivery. Three had urinary tract infections. One was under care for bronchitis, bladder infection, abdominal pain, grand mal seizures, all problems experienced by one student. And one student was treated with an infection from a human bite and was going to need plastic surgery.

Six students experienced severe nausea and vomiting. Five students experienced severe anemia. One of them was a third pregnancy and she required transfusions after her second delivery. Another student was diagnosed with aplastic anemia after her delivery. This may not have been related to her pregnancy but it is a serious medical condition that may have been aggravated by her pregnancy.

Other medical conditions, severe asthma. Another student injured in an automobile accident during her pregnancy. Back pain, hip pain, abdominal pain. One 17-year-old student was pregnant, had a mitral, aorta and tricuspid valve insufficiency, so she had a major cardiac condition and probably was not the best candidate for a pregnancy.

Scoliosis. This particular child has one lung. She is pregnant and she was having frequent shortness of breath. Gestational diabetes. Two. One was on insulin. One child was treated for polyhydramnios. Excessive amniotic fluid. Two experienced twin pregnancies. Two children followed for intrauterine growth retardation. And one student delivered with no prenatal care.

I can go on to some of the psychosocial problems. One 16-year-old pregnant student whose parents died a few months apart and then her brother died and was really experiencing some problems.

One student was abducted by her parent and taken out of Fresno. One student was hospitalized at Kingsview due to substance abuse during her pregnancy.

One 17-year-old pregnant student was living alone. It was her second pregnancy. She was totally unsupervised. Two students were living in group homes. One was a runaway.

Do you want me to go on with the health problems——

Mrs. BOXER. I think I have—I am getting the point and I am going to have a lot of questions.

Ms. PHILLIPS. Those are some of the problems that the statistics do not cover.

Mrs. BOXER. All right.

Ms. PHILLIPS. Access to care did not seem to be a major problem for our girls. Our nurses scout around. They knew which obstetricians take Medi-Cal. Although a few of the girls have delivered

with no prenatal care, the nurses see that almost all of them receive medical care primarily through the use of the Medi-Cal card.

What is greatly needed is more efforts toward prevention and better case management of students who are pregnant to ensure regular prenatal care and to assist students with psychosocial and educational aspects of this situation because a large number of them do drop out of school.

I am pleased to have this opportunity to share this information and I hope that Federal funding may be increased to provide additional services for pregnant and parenting adolescents.

[The prepared statement of Ms. Phillips may be found at end of hearing.]

Mrs. BOXER. What I would like you to do, if you can, is just take a break for about 3 minutes or 4 minutes. I would like to do this interview so we can let the people of Fresno know what I am learning and we will resume with questions to the panel in less than 5 minutes.

AFTER RECESS

Mrs. BOXER. I would like to call the hearing back to order. And I would like to direct some questions to our second panel which was really excellent.

I wanted to say to the panel that I appreciate your patience in allowing me to do this break, because I feel that the people need to know what we are learning in these hearings, and I have learned a tremendous amount so far, and was glad to be able to share it.

Dr. Northway, I want to compliment you on your excellent testimony and your summation in which you say that health care should be a right for all children.

I think frankly that we need to develop a system where every child has a guaranteed right to health care because, as you point out, it is completely ridiculous to believe that we can survive as a Nation if our children are not healthy.

So we need to develop this. You know, in our Congress now for the first time we hear talk about national health insurance and every single American having either his or her own private insurance or being able to get access to insurance that they can get access to through the Federal Government. It is the first time that I have ever really heard talk about that.

We also have a bill by Congressman Stark which would expand Medicare to every American. So that what he considers a successful Medicare program would be expanded to extended to everyone.

Have you given much thought to how we can get to the point when we do have all of our people covered with health insurance, have you given any thought to how we could go about this?

Dr. NORTHWAY. I think so. I am certainly not the world's expert in this regard, and I think you will see that Congress will hear from the National Commission at the end of March our recommendations. But one of the things that strikes me is in fact we do have quite a good private health insurance industry in this country. And there is competition between those companies. And I think that that in itself is very healthy and it is sort of a watchdog situation so that one company competes with another.

What I would hate to see us do I think is to get rid of that total industry and say go to a national health insurance system that is run by the Government, whether it is run by the State or the local or Federal Governments, because it does away with the competition. The bureaucracy has a tendency to grow. The paperwork has a tendency to accumulate. And access has a tendency to go away.

So what I would like us to do is to build on the system that we have that works. And if the Government is involved in any way, it would be to a certain extent in paying premiums, not necessarily in paying bills.

And certainly there are many of us now who have our own insurance policies and we pay our premiums and the companies bill us and do their kinds of things to make sure that they are controlling costs as best they can.

Then there is the group of people who are working that are not insured, and I really believe that has got to be taken care of. I just find it sort of very distasteful that somebody is running a business and doesn't provide health insurance to his employees and expects the rest of us to pick up the tab, either by increased premiums to the private sector to take care of uncompensated care, or somehow through the Federal and State government programs.

And then there is the third group of people who are in poverty or who are in near poverty, those people, it seems to me, that their premiums need to be picked up by society, and we call that the Government. And whether that is done at the Federal or State level, I do not have a big feeling about that. But what I do have a feeling about is that the eligibility for these programs ought to be standardized across the country, and they ought to be standardized at a very reasonable level that everybody understands.

It is not fair to have broad eligibility in California and most of our people do get covered, at least most kids get covered, whereas maybe in Mississippi or some other place children do not get covered.

On the other hand, if you are going to do this, you have got to pay the people that are taking care of the people what it costs. And we can get into all of that and I know that people say, "Well, the cost of health care as a percentage of the gross national product is too high." Well, who says it is too high? I mean why is 15 percent too much? And what is right? Maybe it should only be 1 percent? And we walk around with a bunch of unhealthy people.

I think the people in this country are getting a fair shake. We are living longer. Those of us who have access are living longer. And we have access to the greatest technical explosion in modern health care you have ever seen. It is expensive. But is it wrong to spend that kind of money on health care? I do not know. And I can tell you that in the medical profession, and even at our own lunch tables, we will sit around and say, "Gee, the premiums are too high." But as an individual, when we go through the operating room and look up at the doc just before he gives us the anesthesia, and say, "Hey, doc, spare no expense on me."

So it is a funny kind of situation, but I think the American public is getting their money's worth. Unfortunately, a larger and larger percentage of the population I feel is not having access to the kinds of things that the majority of the people have.

And so through a system I talked about that I think might be the most effective.

Mrs. BOXER. Let me just reiterate it.

You think for the people who have a system working for them, keep it that way.

Dr. NORTHWAY. Right.

Mrs. BOXER. For the people who are working but their employer does not pay any health insurance, mandate that.

Dr. NORTHWAY. Yes.

Mrs. BOXER. And for the people who are impoverished, the Government pay premiums so they can participate——

Dr. NORTHWAY. Right. They could contract with Transamerica or Aetna or whoever else it is and these people then go on to the rolls.

Now, that is pretty simplified because the Government does not want to pay for a premium for somebody who one month is on the system but the next month has a job.

It does get complicated, but I think that if we looked at it long and hard and put together some reasonable things that would not cheat the Government and get the system done, I think we could do it in this manner.

Mrs. BOXER. What about for the third group and this is where—I have been in this for a long time, I do not have the answers either. I just know what my questions are.

Dr. NORTHWAY. Right.

Mrs. BOXER. For this third group, you are talking about having the Government pay premiums to the private sector essentially.

Dr. NORTHWAY. Yes.

Mrs. BOXER. And then in a sense it is a little like the S&L. We covered all those S&L depositors and we saw what happened when we did not exercise enough oversight and suddenly when we looked, it was too late.

What I am getting is taxpayers are paying for this group of people. What is wrong with the old idea of having clinics for people that are well run and done well and eliminating that whole step of the private insurance and just saying, "Here is your card and when you are unemployed, you use it. And you can go to these clinics and get care." That is going back to a two-tiered system, there is no question in my mind.

But then, again, your point that everyone is getting great health care, I am not so sure. A lot of people I know are not that thrilled that they have to use HMO's, although some HMO's are terrific. Others use private doctors, maybe like it better. So I am not so sure anymore that everybody is so thrilled with the level of health care.

So could you answer that? What is the disadvantage of having a system where, since the Government is paying 100 percent of this person's premium, that we could in fact control the health care that the person would get?

Dr. NORTHWAY. Well, I think—you have heard to a certain extent from Mr. Bleth, is when you have two-tier systems and you have public clinics for the economically underprivileged, they do reasonably well in boom years and in not so boom years, they close up.

Mrs. BOXER. They get too overloaded?

Dr. NORTHWAY. Well, yes, the Government—the local State governments run out of money and so they begin to close their clinics or if there is an economic downturn, more people are not working, so they go to the clinics. They cannot hire more people to take care of them. So in fact it comes back then to the private provider to provide the health care. And I think that is a little bit—well, I think we are running out of that opportunity. You can see it in our own places. We have kept the doors open for everybody.

Mrs. BOXER. Right.

Dr. NORTHWAY. And slowly but surely, it is becoming almost impossible for us to do it. And I am not sure there is any money saved by doing this kind of system, because actually we tax the people in Fresno County three ways for health. One, we pay taxes that pay for the Medi-Cal.

Mrs. BOXER. Yes.

Dr. NORTHWAY. Two, we pay our own premiums which do not just cover us but they cover the cost shift that we have to put on for the people who do not pay at all.

And third, we go out and ask you for philanthropic dollars. It is sort of a hit-and-miss kind of system. And it seems to me that if we think health care is a right, we think education is a right, and we do not say to the poor people, "Go to this school because this is the Government school and everybody else gets to go to the private school."

Now, some people do get to go to private schools, and maybe you could say that some people are going to terrible Government schools because they live in a ghetto, but at least in the broad sense of things, the Fresno Unified School District theoretically provides the same kind of education for everybody throughout.

We do not think of it as a welfare program. We think of health as a welfare program. If you are poor, you are on welfare and that is how you get your health. It should be put in the same context, if you will, as education. We think education is a right.

Mrs. BOXER. Yes.

Dr. NORTHWAY. I believe and I think many of the people in this country are now believing that health is a right.

All this money we are spending on arms, and maybe it is a bad time to bring it up——

Mrs. BOXER. It is a very good time. It is what I have dedicated my career to.

Dr. NORTHWAY. The part that bothers me is we will have the best defended country in the world. Unfortunately they will be defending illiterates and those that are unhealthy.

Mrs. BOXER. Yes.

Dr. NORTHWAY. Which really does not do a whole heck of a lot for us.

And I guess the other issue, and I think that John Telles touched on it a little bit. I would approach it in a little different matter. And I would maybe approach it from the standpoint of the person who actually has the Medicare card. Is that we spend an enormous amount of time, energy and money on the 1 or 2 percent who cheat, but we make everybody feel like they cheat.

Mrs. BOXER. Right.

Dr. NORTHWAY. We make the patient feel like they have cheated, "Are you really not working?" You know, "Did you really tell us all the money you have made?" "Well, no, I have an extra $100." "Okay. We are going to take the $100 away from you."

We spend an enormous amount of time on that and then we let people drop through the cracks and keep them into these terrible situations that they really cannot get themselves out of.

And finally, they are so tired of it that they wait until they are dying and then show up.

Mrs. BOXER. Right.

Dr. NORTHWAY. I have probably given you more problems then you can solve. My life has been changed this year by being on the National Commission and I really am dedicated in some way to working with as many people as I can in Government and in private sector to make sure that our system works. So that the people in this country really do have access to the thing that you and I take for granted.

Mrs. BOXER. Right.

Dr. NORTHWAY. And I am sorry if I have raised more questions than I answered but I think the solutions are out there and if we take the time to do it—we have put people on the moon. We have got to be able to figure out a way to take care of the children that she was talking about. Babies giving birth to babies. How are those families ever going to get out of this system?

Mrs. BOXER. Right.

Dr. NORTHWAY. I will stop. I am sorry.

Mrs. BOXER. No; I thought that you were superb.

Mr. Vang, after this measles experience which was so terrible and Fresno bore the brunt of, what was it, 25 percent of the deaths in the whole State?

Mr. VANG. Children's deaths, yes.

Mrs. BOXER. Children's deaths from this measles epidemic. Do you think that that experience was a learning experience for the community? I do not know much about it. Do you think that things have changed in the community, that they understand more now about the need for immunizations and so on? Can you build on this experience? To build on the tragedy to make something positive come out of it?

Mr. VANG. Sure. I would say that after the measles crisis in all the community as far as the service providers are aware, we learned a good experience. Only now is the matter of health education and I mentioned earlier that Fresno County Health Department does approach the community to work with them and develop a team which they are going to go door to door and provide the health education and they have to start the second step, provide immunization services. And expand the immunization clinics toward impact areas so the community knows where the available clinics that it can have access to.

So I think it is a learning experience for all of us here in the area, in the community as well. So I think if they put this effort and strategy and implement it, then I am pretty sure we will be able to prevent this kind of measles crisis in the future.

Mrs. BOXER. I was very pleased to hear your ideas, your very specific ideas, as to how we can help Fresno County deal with trying

to give health care to people from another culture because it presents an entirely different set of problems to a community. Of course, the most basic is to have bilingual people. I mean that is absolutely key. And I think what we need to do in our health care system, and we do not think about it that much back in Washington really, except those of us from California who have come up against this. And we argue for it. Is that we need to build that into any of our grants and our programs that we have to make room for those dollars, because if you cannot communicate, you are just at a loss.

So I want to thank you for your very specific ideas and assure you that they have been heard.

On the issue of teen pregnancy, it is something that I am almost obsessed with because I think, as the doctor pointed out, babies having babies, it is just a cycle that if we do not break, we can write off a whole segment of society.

And what always interests me. Today I am being picketed outside or something by a group who says this is all hypocritical because I am pro choice. The thing that always intrigues me is that many of my friends who do picket me from place to place and time to time—many of them are not for family planning.

The President of the United States, who wants to outlaw abortion, has fought us on trying to get family planning out not only in this country by threatening organizations who do family planning, that they are going to lose every dollar even though they do not use Federal dollars for abortion, they are going to lose it anyway because they don't tell women that this is an option.

So what we have is a confluence of a crisis in the making and I think we have reached the crisis where we have a period of time where there is no movement for family planning and those who do it, do it at their own risk of being picketed or whatever—at a time when choice is being squeezed and this runaway birth rate.

So what I want to know from you is, do you have programs in the school district for family planning? Are they supported? Are they controversial? Can you give me a sense of how effective they are? They cannot be too effective in the sense that the numbers look like they are growing. Of course, you may have a certain population growing at the same time. So if you could fill me in on that.

Ms. PHILLIPS. We have a couple of programs. I think the issue of teen pregnancy is so wide, involving poverty, self-esteem, all those issues. We have some good programs, "Here's Looking at You, 2000" which includes assertiveness training, decisionmaking skills, those kinds of things. We have a limited family life education program for fifth grade students. We have a program at our senior high school level for 12th graders, Social and Family Living, that covers some of these things. But there are not enough programs addressing the prevention for pregnancy that we need to have.

When even briefly in this community the issue of school-base clinics or prevention of pregnancy programs comes up, we are bombarded with the same type of thing that you have seen as far as picketing, et cetera.

In the school district, school nurses who probably would be the most qualified to provide health education in the school, their fund-

ing is limited as it comes from the same fund as teachers. Teachers have difficulty providing the health education that they need to do. They need to teach reading, writing and arithmetic and all those kinds of things. They do not have the time, the background, the knowledge to do health education. The school districts do not fund school nurses because they need the money for teachers.

Mrs. BOXER. Right.

Ms. PHILLIPS. If there is any support that I can give, and, of course, you know I represent school nurses, is that if we had public health nurses, which is what school nurses are, in the schools to do some of the health education, I think in those communities where they have better staffs, you would see a better prevention ratio.

And the same thing Mr. Vang mentioned about the measles epidemic and working with our Southeast Asian families. If we can teach and do health education with our Southeast Asian kids, they can go home and carry that information to their households. With any kind of health problems, there is a lot that we can do in the way of prevention if we had more health education. It is not being done.

Mrs. BOXER. Well, the thing is, the school is a focal point.

Ms. PHILLIPS. Right.

Mrs. BOXER. And I remember the arguments all through when my kids were in public school. Now they are in their twenties. But the argument was, "Well, school just can't do everything. We can only do this, this, this."

Ms. PHILLIPS. But they are the community.

Mrs. BOXER. But the point is, this may be an opportunity to break through some of the problems. They are there. You can reach them. And it seems to me tragic that we do not take advantage of it. Now, we cannot put that burden on the school. But it seems to me the perfect opportunity to have a very good public health program which would include family planning.

And the risks of contracting AIDS. It is hard to believe that people would oppose such a thing. People are dying.

Ms. PHILLIPS. We are not doing an effective job of AIDS education either.

Mrs. BOXER. And it is all part and parcel of the same thing, whether it is drug education, AIDS education—I mean it is all health for our young people, preventing pregnancy.

There is a program in Chicago that apparently has made tremendous inroads, where there is a lot of family planning. There is also help if a young woman does become pregnant and has a child with care at the schools and other things to help that young woman be able to break through.

I want to thank all of you because, as I told the television people, what you are doing for me is you are giving a face to a lot of problems that you read about nationally. You have got them here in amazing numbers. When you tell me that 50 percent of the kids are going to be on Medicare at the rates it is going, that is extraordinary. That means half the children in Fresno are living in poverty or would be living in poverty.

Dr. NORTHWAY. Right.

Ms. PHILLIPS. Right.

Mrs. BOXER. Nationally 25 percent of the children are living in poverty. So to me it is an eye opener. And, yes, we can get our arms around it now. But we have to make the choices, those choices and those priorities. And one of the things that I was saying to one of the reporters is that with the Middle East crisis here, the peace dividend concept is being taken away by the President at this stage when he says he wants to continue to build the stealth bomber and he wants to continue to develop the Midget Man missile and he wants to continue with Star Wars.

Now, these are weapons meant for the Cold War, for the Soviet Union. And that war is over. And so to say that we need to continue to spend these billions of dollars that we so desperately need here in Fresno, just a tiny part of a Stealth bomber would do it, you know, is ridiculous. And that is why these hearings are so important. When I set them up, I had no idea that we would be in this crisis situation which we all pray will go well and we will have a diplomatic way out.

But I think it is very important for those of us who care about these issues to make the connection. And when you said, "I hope I am not speaking out of turn," whenever I speak to doctors, to hospitals, to people in health, I always talk about the connection. Because as you point out, yes, we are spending 11 or 12 percent of the GNP, and the reason we are having trouble spending more, and a lot of us feel we should, is because we are spending it somewhere else and it is called, "I am preparing for nuclear war." So there is a definite connection.

And so this hearing comes at a very important time for me because your comment that, you know, we can win any war, but if we are protecting people who are too sick to even enjoy what we are defending for them, we have not really done much for society, so I could not thank you more. I mean you all have been superb and have really helped me. I am very excited with this testimony and will bring it back to my colleagues. Thank you very, very much.

Dr. NORTHWAY. Thank you for coming to Fresno. We feel encouraged that someone like you is sitting in Congress.

Mrs. BOXER. Thank you. Thank you very much.

We would call forward our third panel, Bruce Satzger, administrator and chief executive officer of the Valley Medicare Center at Fresno; Jack Waller, chief executive officer, Selma District Hospital; Karen Short, registered nurse, intensive care nurse, Valley Medi-Cal Center and president of the Fresno Local of the California Nurses Association; and Carol Davis, board of trustees, and chairman of the Legislative Committee, John Fremont Hospital.

Just wait one second. I have to do one quick little bit of business.

I want to welcome you. You are our wrap-up panel. And why do we not start right in with Mr. Satzger.

STATEMENT OF BRUCE G. SATZGER, ADMINISTRATOR, CHIEF EXECUTIVE OFFICER, VALLEY MEDICAL CENTER OF FRESNO

Mr. SATZGER. Good morning, Congresswoman Boxer, and welcome to Fresno.

My name is Bruce Satzger and I am the administrator of Valley Medi-Cal Center of Fresno. It certainly is a privilege for me to be

with you today and to speak on this subject, Healthcare Crisis: Problems of Cost and Access.

May I begin by describing Valley Medi-Cal Center of Fresno and its role in health care access and delivery for the citizens of not only Fresno County but really, in many ways, the citizens of the entire central valley of the State of California.

Valley Medi-Cal Center is a county owned and operated institution. It is the primary health care provider for the indigents of Fresno County. It provides both primary care services as well as specialty and subspecialty services for the citizens of our valley.

It is also the level one trauma center and, in fact, is the only level one trauma center between I believe Bakersfield and Stockton. In this role, it is a resource for all the citizens of the central valley, not just the indigent population.

Additionally, it is the burn center for the central valley, again, providing a resource for all of the citizens of this part of the State.

As you are aware, these two services, trauma and burn, are very high cost, requiring intensive levels of care services. They require highly trained physicians, nurses, technicians, technologists, as well as the appropriate equipment. These high-cost services are not being reimbursed appropriately and as a result we have seen a particularly acute crisis during the last 12 to 18 months in the southern part of our State, in the Los Angeles area. They at one point in time had approximately one-half of their trauma centers closed.

If we were in that situation and being the only one available in the central part of the State, one can see the potential havoc this would create. And this is not only in the access for emergency care, but also in our particular community of Fresno, we get into situations where we have no intensive care beds available at certain times of the year.

Valley Medi-Cal Center is also a teaching institution affiliated with the University of California, San Francisco Medi-Cal School. We have approximately 150 residents in 10 different programs. These programs are primarily based at Valley Medical Center. There are many benefits to this area as a result of the teaching program. One of the major benefits is that the program is, in essence, a feeder of physicians to the central part of this State. Approximately one-half of our residents stay in the valley area to practice medicine.

Also another significant benefit is that the residents provide substantial care to our patients. From an economic perspective, the cost of a resident who, as we know, is a graduate physician, is much less than having to hire separate licensed physicians or even other health care practitioners.

Following my discussion of the role of Valley Medical Center leads me into what I will call the necessity of developing a health care policy. And, of course, this has been addressed by previous speakers.

As you well know, we do not have a national or even a statewide health care policy. And as has been discussed, is health care a right or is it a privilege? I believe and it has been supported today that everyone feels that it is a right. If that is the case, in my opinion, we are moving more and more away from it being a right to it

being a privilege. And if it is to be a privilege, then many individuals will not have access to health care.

As to the cost of health care, as was discussed previously, what is an appropriate and an acceptable cost level? As we discussed, is 12 percent GNP too high? Right? Too low? Demand has increased dramatically over the years, both on an inpatient and an outpatient basis. The technological development in the health care arena is astounding. There have been significant procedures and equipment that have been brought to the health care scene that have had a significant impact in the diagnostic and treatment of many health problems. This equipment is very costly. But it has certainly had a marked impact on the improvement in health care.

In our particular example, being a county facility, we have not been able to take advantage of some of this technological development as has our peers in the private sector. For example, we are just about to begin to have MRI capabilities at our institution, a tertiary care institution in the valley. This has been available for a couple of years or more and now we are first going to have the opportunity to have this service available for our patients.

To support this equipment and other procedural developments, there is a need to have a highly trained group of allied health professionals. This not only includes nurses, but also laboratory technicians, pharmacists, respiratory therapists, nuclear medicine technologists, et cetera. These individuals are highly trained and, as a result of that training, are highly compensated.

Additionally, the demand for these people is far exceeding the supply, which has had an adverse impact on the salary costs for hospitals. At Valley Medical Center, for example, we currently have vacancies. We need six pharmacists out of an assigned quota of 20. We need 10 laboratory technicians out of an assigned quota of 47.

Hospitals are much more conscious and aware of the appropriate utilization of their resources and services. The quality assurance and utilization review functions have improved dramatically and I feel they have had a positive effect on efficiencies in health care delivery.

For our institution, two of the key reimbursement areas in the Medicare program are the capital passthrough issue and the educational reimbursement issue. We are an aging facility, both as to structure and equipment. We definitely need access to capital as well as the assured reimbursement. If capital is added to the DRG formula, it will have a negative impact on an institution such as ours.

Since we need such a heavy investment in capital to improve our facility and improve the equipment that we so desperately need, we need to maximize our cash flow, which I do not think will happen if we go forward with putting the capital as part of the DRG formula versus having passthrough.

Also, if the reimbursement for both direct and indirect medical education continues to be decreased as it has been, we will see a risk to the actual viability of our teaching program. The total cost of education at our institution, both as to faculty and residents, is a little over $10 million a year.

The Medicaid program, which, as you know, is called Medi-Cal in California, is woefully underfunded, particularly for outpatient services.

In our area, and this has been discussed, we are starting to see where it is very difficult for a Medi-Cal patient to be seen, particularly by a specialist or subspecialist outside of our institution. The physicians no longer want to see these patients because of the reimbursement situation. Again, this has been discussed.

Also, more and more physicians are not wanting to be on emergency call panels in the emergency rooms of many of our hospitals. The Federal role in the Medicaid program certainly needs to be reviewed. In our particular situation, again, on an outpatient basis, we have about 133,000 visits a year in about 65 different clinics. And we have in addition to that about 60,000 visits through the emergency room.

If you add those two together, we are approaching 200,000 visits. Although some of these are repeat visits, that is almost one-third the population of Fresno County.

Another area that severely impacts us, and, again, this has been discussed previously, are the programs dealing with reimbursement for the aliens and immigrants.

As Mr. Bleth has stated, the State Legalization Immigration and Assistance Grant Program, or SLIAG, is no longer going to receive Federal support, I believe, in 1992. This will have an acute impact on our area.

Fresno and the central valley have a high percentage of Hispanic and Southeast Asian residents. Many of these individuals have come to this country as a result of the various Federal policies and initiatives. It is wonderful that we have opened our doors to these people, but the service and health needs are enormous. These needs are putting an economic burden on the local communities which are having a negative impact on the economic well-being of local governmental agencies. Federal help is definitely needed in order to overcome a deteriorating local situation.

In conclusion, I certain feel from my perspective that as a county hospital administrator that we are in a severe health care crisis and it is not improving but only getting worse and worse.

Something will have to be done but thus far we do not appear to have the interest or leadership to solve this situation, both at the Federal level and particularly at the State level. The last State budget, for example, was a tragedy, and I cannot emphasize it enough, a tragedy for health care for the poor of our State.

We are more than happy to cooperate in the development of a solution but we need the interest and leadership of individuals such as yourself.

Again, thank you for allowing me this opportunity to speak with you today.

[The prepared statement of Mr. Satzger may be found at end of hearing.]

Mrs. BOXER. Thank you very much, Mr. Satzger. Mr. Waller.

STATEMENT OF JACK K. WALLER, CHIEF EXECUTIVE OFFICER, SELMA DISTRICT HOSPITAL

Mr. WALLER. Congresswoman Boxer, welcome to Fresno County and good morning.

Mrs. BOXER. Thank you.

Mr. WALLER. I am Jack K. Waller, chief executive officer of Selma District Hospital, a public entity, a 65-beds acut care hospital, located in the southern portion of Fresno County.

My statement this morning will cover the following three points. Some discussion about Federal funding for health care services. No. 2, the overall cost of health care. And, last and most importantly from my perspective, access to health care in the rural setting.

On the first point, as a practicing rural hospital administrator, I am totally dismayed at the Medicare funding cuts over the past 5 years. The DRG payment system under PPS, Prospective Payment System, is a completely inequitable situation for hospitals under 100 beds. The bureaucratic paperwork is unreasonable and the utilization review process costs our hospitals even more money. Also the risk to small hospitals is greater since their urban/rural differential is significant, somewhat on the order of 14 to 17 percent.

Small hospitals are not fairly treated under the current Medicare PPS system. Specifically, the proposals for add-on capital equipment, which my colleague Bruce Satzger just referred to, the DRG rate will be a total disaster particularly for the small hospitals in the State of California.

Most rural hospitals were built in the 1950's with Federal Hill-Burton funding, which was a Federal program. These facilities are now due to be replaced and the add on to DRG's will not be adequate to accomplish that replacement.

On the second point of the cost of health care, I believe that ultimately we will see 15 percent of GNP spent on health care. This would be an increase over the current rate of approximately 11 percent. Quality health care is manpower and technology based. Therefore, as new equipment and new technicians are introduced, the cost goes up. However, patients benefit from the improved quality of life with examples that I would give, total hip replacement surgery, cataract eye surgery, and MRI imaging of arthritic joints. Each of the items I have just mentioned are in fact offered at my 65-bed acute care facility.

Senior citizens are able to use my hospital since it is close to their homes in the southern portion of Fresno County. No public transportation exists in this area and some seniors do not drive automobiles at the advanced ages of seventies and eighties. We cannot turn away from the needs of these older Americans.

On the last point of access to rural health care, I am convinced that rural services are absolutely mandatory. Our Federal health care system has been supported over the years by rural workers' contributions to Social Security. These payers should be able to receive benefits in their small towns and local areas. I guess my point would be that this country was built on the farms, small shopkeepers, and small business enterprise. We cannot abandon our senior citizens at their time of health care need.

To expand on this point, let us keep in mind that rural America has been hit hard by service reductions from the State, and to add Federal cuts would be overwhelming.

I would point to some additional statistical information about rural health care in California. We do have 83 rural hospitals; 49 of those rural hospitals are in fact designated as Medicare providers, 27 are sole community providers—1.3 million residents in California reside in rural counties. And we would identify that 25 of the rural hospitals do have, as well as acute care, distinct part-skilled nursing and 14 of the rural hospitals have swing-bed programs.

During 1989, the small rural hospitals discharged more than 1,119 patients. This was more than the total discharges from all other hospitals in each of eight other States in the United States. Only 19 of California's 83 rural hospitals are located in communities with more than 10,000 residents. Rural hospitals make services available and access to small populations. California's rural counties have a total population of 1.3 million residents projected for 1990. Larger than the total population predicted for 1990 in each of 12 other States in our Nation. Due to problems of weather with respect to fog, snow, mountains and flooding, 85 percent of rural hospitals in California reported that sometime during the year the trip to the next closest hospital can be over 2 hours.

Although California is one of the Nation's largest rural States, its rural health care problems are sometimes overlooked because California is one of the largest urban States as well; 85 percent of California roads are urban; 15 percent are rural.

What I would like to do at this point would be to just in summary suggest that we do need Medicare reform. I think this Task Force and your help can be instrumental in that effort.

And, Congresswoman Boxer, I appreciate this opportunity to give testimony and would entertain your questions at the conclusion. Thank you.

[The prepared statement of Mr. Waller may be found at end of hearing.]

Mrs. BOXER. Thank you so much. Ms. Short, we welcome you and ask you for your testimony.

STATEMENT OF KAREN SHORT, R.N., INTENSIVE CARE NURSE, VALLEY MEDICAL CENTER, PRESIDENT, FRESNO LOCAL, CALIFORNIA

Ms. SHORT. Thank you.

My name is Karen Short. I am a registered nurse at Valley Medical Center with 5 years' experience in the intensive care units.

You have invited me here this morning to present the nursing perspective on the present and future state of access to health care in California and I appreciate that. As one of my main functions as a registered nurse is to advocate for a patient's right to quality health care for all patients who need it.

When budget are cut our funds are cut. One of the first areas to go is staffing. And when ancillary departments cut personnel, nurses find themselves drawing blood, making ventilator changes, running for supplies, cleaning floors and bedside, and a host of

small time-consuming tasks which take the nurse away from the bedside.

Studies indicate that fully 40 percent of the registered nurse's time is spent in this type of activity. Registered nurses can do these tasks and they do, in addition to the work that only the nurse can do. In the future, if nurses are required to pick up more of the work of other departments due to cuts in their personnel, we will become more and more task oriented, and this was only be exacerbated by cutting nurses members as well.

What will be gone is the process of nursing. There will be no time to talk with patients, to find out if they eat correctly, to find out if they know how to take their pills, which ones to take for what, how often to take them. There will be no time to allay their fears for their future health. To teach them how to cope with the limitations imposed upon them by age, injury or infirmity. There will be no time to give them the knowledge necessary to prevent repeated returns to the acute care setting. And there will be no time to look for subtle changes in the patient which can only be found by spending time with the patient. And no time to help the families and patients cope with the crisis they are in.

You cannot sit down with the patient and say, "I have 5 minutes to build rapport with you, identify your problem and solve it for you." It just does not work that way. And time is money.

Health care systems are failing nationwide because our society has failed to make access to health care a priority. We think it is only the poor who will be affected by cutting funds, and this is not true.

Valley Medical Center is the trauma center for the San Joaquin Valley and, as such, we treat anyone and everyone who enters our doors. In the past, this has included judges, physicians, Ph.D's in physics, vice presidents of Fortune 500 companies, children burned playing with matches or hit while riding their bikes to school. Firefighters, law enforcement personnel and paramedics hurt in the line of duty. And anyone foolish enough to grow old without private insurance. It could include your children, your parents, you, me, or anyone driving a car. Anyone driving a car on the city streets of Fresno on Freeways 41 or 99 all the way over to Interstate 5 or just pulling out of their driveway will be brought to Valley Medical Center Trauma Center if they are seriously injured. And I think we should all think about that the next time we get into our cars.

Public hospitals, such as Valley Medical Center, are for the public and we are the public. We could very well end up in the facility that we consider only for the poor. And if you still believe that your loved ones will not need the services of Medical Center, I sincerely hope that you are right. But if you ever do need us, we need to be there to meet your needs. Not just the tasks, but the process of returning people to society with the tools and the knowledge they need to go on with their lives. You do not get that from a building. You get it from the people who take care of you 24 hours a day, 365 days a year. People who are there for you and for thousands like you year after year after year.

It is imperative that each of us as individual citizens as well as in our own positions of relative responsibility and through our elec-

tive representatives let it be known that access to health care is a priority item and needs to be funded as such, as a priority, at the Federal level. Thank you.

Mrs. BOXER. Thank you so much for your excellent perspective.

And for our final witness I would call Carol Davis, Board of Trustees, John Fremont Hospital.

STATEMENT OF CAROL DAVIS, DIRECTOR/TRUSTEE, JOHN C. FREMONT HOSPITAL

Ms. DAVIS. Thank you, Congresswoman Boxer.

Mrs. BOXER. By the way, before you begin, I wanted to tell the rest of you because you are my wrapup panel, I am going to throw a question at you and I want to tell you now so you can think about it.

You have sat here through most everything. You have heard what I have heard. You know I am going back to Washington and I am going to have to fight for this health care because we are going into the automatic budget cuts of Gramm-Rudman if we do not come up with an alternative.

Give me a few sentences that I should take back from Fresno to bolster my case, two or three. We will continue, Ms. Davis. Go ahead.

Ms. DAVIS. Congresswoman Boxer, and ladies and gentlemen. My name is Carol Davis and I am an elected director/trustee of John C. Fremont Hospital District in Mariposa County. Fremont Hospital is the only hospital in our rural mountain county.

Today I will address three problem areas, nursing, physicians and building structure. Nursing in a rural hospital demands multiple expert skills and diverse knowledge of each nurse. Many people believe that because a rural hospital is small in size and because it does not contain many specialty departments the knowledge needed and the skills required of nurses are less than in larger hospitals with highly specialized departments.

The opposite is true. At Fremont Hospital the registered nurse who cares for patients is proficient in acute, med-surg, pediatrics and obstetrics. She also has responsibility for directing by radio the activities of the ambulance personnel in the field. A mobile intensive care nurse, an MICN, a certification is required for this. The hospital receives no compensation for this service. The ambulance patients may be admitted to Fremont Hospital, but more frequently they are sent on by ambulance or by helicopter to a larger hospital that has sophisticated and revenue-generating equipment.

The RN must be skilled in emergency room care and have the knowledge to oversee geriatric patient needs. The nurse that possesses all of these requirements certainly is entitled to compensation equal to that paid to nurses in larger hospitals. Yet rural hospitals receive as much as 30 percent less compensation from Medicare for the same services rendered in urban hospitals. Thus, the hospital does not have the money to pay the wages the nurses deserve. Nor the money to compete in the nursing shortage that exists.

Fremont Hospital operates a 24-hour emergency room service with an ER physician in the hospital at all times. The physician is

paid x number of dollars per hour 24 hours a day. In larger cities, the ER doctors see patients all the time. We see an average of 9.5 patients per day in the emergency room which does not cover the simple cost of operating an emergency room. We all know that early treatment of accidents and emergency illnesses are essential. The residents in rural areas and the visitors from the cities need to have emergency services available. Yet there is no plan to compensate for hospital losses. The rural hospital is just going further in debt and pays its employees less.

Mariposa needs more physicians in order for the residents to receive adequate health care. Recruiting physicians is expensive. Most demand a 6-month subsidy. There are no Federal programs that I can find to help. The one program I did find was for building doctors' offices which required five doctors in a group practice. Getting five doctors together in the city might be easy. But recruiting five doctors at the same time is unrealistic in a rural area.

The last issue is building structure. Mariposa has a high retired population. Fremont Hospital has 10 skilled nursing beds. This unit was built 26 years ago. A survey has showed that 54 additional skilled nursing beds are needed. They were needed on the day the survey was completed. Many people suggest converting acute care beds to skilled nursing beds. Now, we do use our acute care beds for swing beds. In fact, we were the first hospital in the State to do that. But for many reasons, it is awkward, inconvenient and a strain on nursing personnel. The rooms are too small for today's requirements. There is no place to store wheelchairs or personal belongings. The bathrooms are not accessible to wheelchairs. Is the answer to remodel? No.

Fremont Hospital was built 40 years ago under the Hill-Burton Act for which the community is very grateful. The structure is a class A building. That is, it is poured concrete. The outside walls and the inside walls. It will resist an earthquake. It will resist remodeling. The only way to move a wall is with a jackhammer. And that is not feasible and it is not cost effective.

It is time for selected rural hospitals that were built under the Hill-Burton Act to receive modernization and replacement funds. The difficulty that rural hospitals have had and the multiple closures demonstrate the need for assistance in order to continue to provide health care to rural communities.

Thank you for listening and thank you for caring.

[The prepared statement of Ms. Davis may be found at end of hearing.]

Mrs. BOXER. Thank you so much. I found this panel to really round out everything that I need to know.

And now I am going to ask you that key question. I am going back and I am going to talk to my colleagues who were not here.

What did I take away from Fresno? Do you want to try it?

Mr. SATZGER. Well, if I may, I will make a couple of comments or maybe statements that I think we may cue that.

Mrs. BOXER. I want you to do it in two or three sentences.

Mr. SATZGER. All right.

Mrs. BOXER. I am going to be meeting my Chairman, Leon Panetta, who you probably know is wonderful. And he is going to fight the battle for health care with this in a summit and I cannot spend

too much time with him. He is going to look at the record and I want to try to be as brief as I can. So give me a couple or three sentences of what I should tell him.

Mr. SATZGER. Health care programs are not covering or coming close to covering costs. I think that says it for Fresno. I think it says it for everyplace. Medicare is a budget balancer. It is not related to health care costs. So it is not making any sense from a health care perspective.

We need health care professionals. We need to encourage the education, not only of physicians, and I think there is a great dispute in this country that we have too many physicians. We do not have enough in the rural/urban area of central California. And not only physicians, but, again, as I mentioned, nurses, pharmacists, et cetera. We are not promoting this from an educational—we are not giving incentives. Take care of the citizens relocating to our area. Again, the immigrant population.

Mrs. BOXER. Yes.

Mr. SATZGER. We locally cannot bear that burden. We need some help. Make capital available. Again, the hospital that you have heard today, we need to replace and improve our facilities and our equipment.

And the other one is—I will call it, if it is a word, overregularized. Too many regulations. That is costing us a lot of money. I think we need to relook at what is the purpose of the regulation and what it is accomplishing and what is the cost. What is the cost-benefit ratio of regulations?

Mrs. BOXER. We did not do enough regulation of the S&Ls so we doubled yours.

Mr. SATZGER. That is right.

Mrs. BOXER. Mr. Waller, can you add to my wisdom here?

Mr. WALLER. Yes, just a few comments.

I think what we have heard this morning has been that the system is failing. And I think that the Congress has an opportunity to do some shifting of priorities and resources. And that I think the failure to act, and for Leon Panetta, I would indicate that we are going to have generation damage. The next generation is going to be significantly damaged——

Mrs. BOXER. That is really interesting——

Mr. WALLER. If we do not address this issue at the present time. So those would be the words that I would leave with you. That we are damaging our future by not acting at the present time. Thank you.

Mrs. BOXER. Thank you. Ms. Short.

Ms. SHORT. I think we always feel that bad things are going to happen to the other guy and they are not going to happen to us. And that is a coping mechanism. That is self-preservation——

Mrs. BOXER. Right.

Ms. SHORT. Because you cannot live with that kind of fear everyday that when you get into a car you are going to crash and you are going to end up in intensive care for 6 months. You cannot face that kind of fear everyday and yet survive and accomplish anything.

But people need to be aware and they need to plan for that possibility. And I think people need to know that cuts that are made

today may adversely affect each of us personally very up close in the future. And we need to plan.

Mrs. BOXER. Thank you. Ms. Davis.

Ms. DAVIS. Thank you.

I agree, of course, with what everyone has said, but also people, especially people in rural areas, which is what we are talking about, need to have health care access near their homes.

We have a large retired community. There are people that travel 2 and 3 hours to see their elderly spouses, and these are elderly people doing the traveling and then they have to travel back. As we get older we have less energy. This becomes a health strain on the person who is not ill. We have people taking care of elderly spouses in their homes to the point where their own energy is drained and they become ill.

We need to be able to pay the health provider in the rural area at the same rates that the health provider in the urban area is paid. They are just as valuable a person.

Mrs. BOXER. Thank you. I am really glad that we did this little exercise because it underscored some of the things that I have been thinking. I am going to just give some of it back to you.

As an overview here, it has been very important because I have taken the subcommittee to various urban areas. And I have not had this perspective before.

I am familiar with the problems because I have read about them, but here I really see the face of some of the problems. So many that you talked about today. As immigrants enter a society there needs to be a better way to reach them. The Federal Government has a responsibility. It cannot become the local government's responsibility.

And over and over again the reimbursements are not covering the cost and as a result of that, people are not getting access. And certainly people deserve the access. There should be fairness between the rural and the urban reimbursements and pay scales.

I think the notion of generational damage is something I am really going to take away from this hearing because here we sit and with the prediction that we are going to have half of the children in Fresno living in poverty and all the problems that attend that including very little prevention, as we heard from our school nurse. And the ability of the schools to really help with prevention. Again, if we made that a priority.

And I guess that Ms. Short's point that it isn't a we versus them situation. The health care system is for all of us and therefore we all have a responsibility to make sure that it is there because there but for the grace of God go all of us.

And so we have to, as a society, give it a priority. And, of course, the overall theme that I have been hammering for 8 years, which is that our quality of life encompasses education and health care and housing and the things that we need everyday. And that it doesn't do us much good to be able to destroy every man, woman and child in the universe 50 times over if we do not have a decent way of life for our people.

I want to welcome here senior Senator Nick Bronson and if you would just raise your hand, I will just quickly tell you that we will put your statement in the record. The record will be kept open for

2 weeks and Lynne Richardson will tell you how to do it. I know and work with your son. I have known him for many years since I was in local government. I admire him greatly. I can see he's a chip off the block.

Mr. BRONSON. I do not have a written statement. If I can just make a very few comments.

Mrs. BOXER. Well, we cannot do it unfortunately because I am due at 12:30 and I have got this panel just about to the second. But we can keep the record open for 2 weeks and I am sure that Assemblyman Bronson will help us——

Mr. BRONSON. You could not hear five sentences?

Mrs. BOXER. Yes. I could hear five sentences.

Mr. BRONSON. All right. First of all, I heard the legislator say why spend money on the seniors, they are going to die soon anyway. And that kind of charged my batteries.

Mrs. BOXER. Right.

Mr. BRONSON. You have heard of hospitals, clinics, doctors, nurses and so forth, but nobody says anything for a person on a fixed income. Drugs. If somebody can get drugs for $3 at Kaiser-Permanente, why should I pay over $50 for the same drug at Long's. Ambulance. I took a ride in an ambulance. It costs me over $450. I could take the same thing in a taxi for $12. Lawyers. The cost of lawyers, vitamins, health education. All those affect the cost of living. So what we seniors are suggesting is that you need to take a look at the total picture of health care—mechanics have a saying. They say, "If it works, don't fix it." The other side of the coin is, "If it isn't working, then fix it."

Mrs. BOXER. Exactly.

Mr. BRONSON. Now, the testimony you have heard today tells you and the figures you presented at the beginning, it is not working.

Mrs. BOXER. Right.

Mr. BRONSON. Well, fix it.

Mrs. BOXER. Well, that is exactly the point of this hearing, to find out from the perspective of Fresno where the problems are. I am not going to tell you that I can fix it. I can tell you I am going to bring back what I have learned today to my colleagues. And more importantly really to the whole debate on health care. Because we are never going to fix it if it is not a priority for this country. Because gone are the days when people can say, "I want this. I want that. I want this."

Now, it is a matter of choices. We have got a deficit. We have got to make hard choices. I am ready to make those choices. If I could tell you that I could go back and convince President Bush that those same choices should be his, I would not be honest with you.

Mr. BRONSON. As a senior legislator for a number of years, advocating that universal health care.

Mrs. BOXER. I understand.

Mr. BRONSON. That everybody have a available health care. I went to Yugoslavia. Now, we in the United States donate a lot of money to Yugoslavia. Just give it.

Mrs. BOXER. We do?

Mr. BRONSON. Yes, we do.

Mrs. BOXER. I do not think so.

Mr. BRONSON. And my uncle says to me, "If you get sick here, I will have a doctor taking care of you in 15 minutes and it won't cost you a cent."

Now, if we can do it there, why cannot we do it here?

Mrs. BOXER. Well, I am not at all sure you want to be in Yugoslavia. But be that as it may, let me just say that I have appreciated all this. The record will be kept open for 2 weeks.

We stand adjourned.

[Whereupon, at 12:15 p.m., the Task Force was adjourned until Friday, August 24, 1990, in Modesto, CA]

HEALTH CARE CRISIS: PROBLEMS OF COST AND ACCESS

FRIDAY, AUGUST 24, 1990

House of Representatives,
Task Force on Human Resources,
Committee on the Budget,
Modesto, CA.

The Task Force met, pursuant to notice, at 9:30 a.m., in the Stanislaus County Board of Supervisors Chambers, 1100 H Street, Modesto, CA, Hon. Barbara Boxer, Chair, presiding.

Mrs. Boxer. I am going to call to order this field hearing of the House Budget Committee Task Force on Human Resources. We are so pleased to be here in Modesto.

Yesterday, I held a similar hearing, and we came away with some startling facts about the status of health care, access, and costs. I hope things are better here. But whatever I do learn, I will take back with me to Washington.

Mr. Condit and Mr. Espy will be here. Mr. Espy is from Mississippi and Mr. Condit, of course, comes from Fresno. They are on their way but because of the press of time and the fact that I want to get everybody in and have adequate time for questions, I am starting immediately.

I have a brief statement I want to read into the record and then I would be honored to call on three elected officials that are here with us. I am very anxious to hear their comments on health care in this area.

This Task Force is charged with the responsibility of recommending funding levels for health and education programs to the full Budget Committee. During the 2 years of my chairmanship, the Task Force has highlighted some of our most critical health care and education needs. Over the last year, the Human Resources Task Force has held hearings on AIDS, Medicare, biomedical research, veterans' health care and the Special Supplemental Nutrition Program for Women, Infants, and Children—the WIC program.

The people best able to advise us on health care issues are the people fighting the battles on the front lines. And that is why we are out here today, to find out how people in our California communities are coping, to identify key problems and perhaps some innovative responses, to take back to Washington.

We are all aware of some shocking statistics. As many as 37 million Americans have no health insurance whatsoever. Medicaid

services cover only about half of our poor children, while 20 percent of our children are below the poverty line.

The United States ranks behind 19 other industrialized nations in infant mortality rate. A baby born in Cuba has a better chance of survival than a baby born in Washington, DC. We have 40,000 infant deaths per year. Over 70,000 babies are born every year to women who have had no prenatal care. These figures are very disturbing.

I have long advocated an approach to health based on the cost-effectiveness of early intervention. We have to reach out to people before they are ill or pregnant or hooked on drugs.

These hearings could not be more timely. We are waiting for the budget summit to resume. The budget resolution assembled by the Budget Committee and approved by the House assumed large funding increases for the National Institutes of Health, Medicaid and other programs for our children. As a matter of fact, it had a children's initiative which I hope will survive. And it held the line on Medicare cuts asked for by the Bush Administration.

Unfortunately, these gains are threatened by the recent economic downturn, the situation in the Middle East, and differences in priorities between Democrats and Republicans.

We are bringing together today local elected officials, health care providers, and community advocates to dramatize health care issues. By your testimony, you can help me and the Members of this Committee bring the truth about health care to the summit negotiators in Washington and to the U.S. Congress.

So I just want to thank you so much for the contribution you are about to make.

At this time it is my honor to call on Hon. Sal Cannella, Assemblyman, State of California. Very nice to see you, Mr. Cannella.

Mr. CANNELLA. Good morning. Thank you.

STATEMENT OF HON. SAL CANNELLA, ASSEMBLYMAN, STATE OF CALIFORNIA

Mr. CANNELLA. Congresswoman Boxer, Mayor Whiteside, Supervisor Paul and others, welcome to Stanislaus County and to the city of Modesto and the 27th Assembly District. I am sure you are aware the 27th District is all of Stanislaus County and part of Merced County.

And the health care situation in California, as you noted on a national level, should be placed on a critical list. Fundamental comprehensive reform on the national and State level is necessary if we are going to break the cycle of runaway costs and declining access. Unfortunately, national and State access seems to be a long time coming.

We must move the institutions with stronger controls, better resource planning and establish a comprehensive health care plan that meets the needs of our constituents—all of our constituents, certainly the Mayor's and yours and mine and the supervisors.

We are also concerned about the impact on employers who generally carry the majority of the cost of providing health care to their employees. A plan must be developed that provides affordable

quality care while addressing the concerns of those who must pay for the access to health care, which is a critical problem.

The crisis in California's budget is going to put an additional strain on an already overburdened system. I think in Stanislaus County and Merced County areas that I represent it has had a tremendous impact on the budget cuts that were made this fiscal year up in Sacramento.

This is a national crisis and we look to the Federal Government for leadership in order to resolve it. Hopefully we can develop situations from the information and insight gained from these hearings here and around the State.

Again, I welcome you to our community. There are many experts in the audience who can certainly add a great deal of information for you to go back to Washington and also the other elected officials.

So once again, I would like to welcome you here, and I hope it is a very profitable day, informationwise.

[The prepared statement of Mr. Cannella may be found at the end of the hearing.]

Mrs. BOXER. Thank you and I am sure it will be. At this time I would call on Supervisor Paul.

STATEMENT OF PAT PAUL, SUPERVISOR, STANISLAUS COUNTY BOARD OF SUPERVISORS

Ms. PAUL. I, too, would like to welcome you to Stanislaus County. I am always pleased to see women in politics. I think it has something to do, maybe, with our training. We are honest, and we get in and clean up and do the job.

I serve on the county's Emergency Medical Committee and I think what you will hear today about the health care in Stanislaus County will mirror those concerns within the health care system statewide.

There are signs that the hole in the State safety health net are widening. Over 5 million people in the State lack basic health insurance. Hospitals, both public and private, are rendering close to a $2 billion annual uncompensated and undercompensated care.

Scores of trauma centers are closed. Hospitals have downgraded their emergency facilities to control exposure to nonpaying patients.

The increases in Medi-Cal reimbursement rates for physicians, hospital and long-term care services have fallen far below medical inflation. This leads to a backlog in services and also to shortages of the providers.

Just this month the legislature and the Governor deeply cut funding for the county's indigent services. The State is on a course of disengagement of funding for health care for the needy, and they leave the counties financially strapped.

Later on today you will hear that our own county-run hospital will look at a deficit of $2.3 million. So I appreciate you taking the time out of your very busy schedule to listen to our concerns.

I am sorry, but I am not going to be able to stay here. I am a health educator and today is a teacher workday so that we can get

ready for Monday when I will be inundated with lots of high school students.

And their major topics that I will deal with that they are very concerned about will be drugs and sex and for me to simply say to them, just say no, is not enough. Thank you for being here.

[The prepared statement of Ms. Paul may be found at the end of the hearing.]

Mrs. BOXER. Thank you, so much, and I thank you for your contribution. It is now my honor to call on Mayor Whiteside.

STATEMENT OF HON. CAROL WHITESIDE, MAYOR, CITY OF MODESTO, CA

Ms. WHITESIDE. Thank you, Congresswoman Boxer. We are all very pleased to have you here and any time we get any sort of focus or attention or recognition of the importance of medium sized cities and national policy it is helpful to all of us.

So often, the issues seem to evolve based on what happens in New York or Chicago or Atlanta or Los Angeles and I am very protective of medium sized cities' roles and must tell you that we have the same kinds of problems and the same kinds of issues as the larger cities.

There has been a lot of talk about changes and growth in the valley and I have been quoted many times speaking about the influx of commuters but when we are talking about health and human services issues, we have to remember that part of the growth in this valley is also caused by an influx of refugees, people who live below the poverty line and who do not have access to adequate health care and other necessary human services.

We have in this county exactly the same health problems that every other major city in the country has. We have seniors who can't get health care. We have children who are not being properly cared for. We have more than our share of teenage pregnancies. We have AIDS, we have cancer, birth defects, and we lack adequate funding for education.

Funding is a critical issue in health care but I would ask you to first work on the development of a national health care policy because if we have a policy the funding problems will fall into place, but absent a policy all we seem to do is shotgun approaches and never solve the big problems.

I would like to commend you and the other Members of the Task Force for being here and tell you that all of us here in Modesto and Stanislaus County and the country and the Nation look to our elected leaders for wisdom and leadership.

We don't always get it and I, as well as anyone, know that it isn't easy, that the answers aren't easy. But the reality is that we would pray that you would take the information that you gain here today and the other series of hearings that you are conducting and use the information well as you look for the development of health care policies and solutions to what we know are very real human needs in this country. We would like to thank you.

Mrs. BOXER. Thank you, Madam Mayor. When you say you look to elected leaders, I hope that you still do.

Ms. WHITESIDE. Well, some of us believe the system works.

Mrs. BOXER. Exactly. Those of us who are in there know that it can be brought to a solution. It has to be.

Ms. WHITESIDE. That is right.

Mrs. BOXER. There are too many special interests and we must rise above them and speak in the public interest.

Ms. WHITESIDE. There is no one else who can do that.

Mrs. BOXER. I want to identify with one other point you made about the importance of an overall policy. I think the problem we face with the catastrophic health care issue was that we just said, all right, here is another band-aid and we are going to try to fix it.

Ms. WHITESIDE. That is right.

Mrs. BOXER. It was not well thought out. It didn't work and I think the lesson there is, without the whole thing, health care for kids and elderly and long-term care, the whole continuum of care, if we try to do just one little segment at a time, it will just be one patchwork.

Ms. WHITESIDE. I couldn't agree more and I think one of the buzz words that we—there are two buzz words that I hear a lot lately and one of them is consensus and the fact that health care problems are not only the interest of the health care industry and the patients and the clients. They are in the interests of the business industry and the Social Security industry and the tax industry and everyone.

And the second one is interconnectedness which we are hearing more and more about. I don't think any of these issues can be treated in isolation from their relationship to everything else that goes on in this country and in our communities and if Congress would recognize that I believe we will have a much better national policy.

Mrs. BOXER. I would like to thank all three of you and I would like to observe that we are at a very momentous time now that the cold war, which called for some sacrifices and was a very difficult time, has ended, and we are in a new kind of war now.

It is really an economic war and economic competition and you can't win if you have a sick population, period, and one that isn't educated and kids having kids because they are our whole future.

And I know that all of you are aware that we have pieces of policy but we don't have a whole policy and that is why being here is so important. I want to thank you for adding a lot to the debate and I look forward to working with you and taking your wisdom back to my colleagues.

Your remarks are going to be put into the written record of this hearing and as these come down from the mountains, at Camp David, where I will be meeting with President Bush, they will be hearing continually from this Member of Congress who chaired the Task Force that, as someone said at the hearing appropriately yesterday, it doesn't help us that we can kill every man, woman or child, you know, 50 times over, with our nuclear arsenal, if the people we are protecting aren't happy, having a quality of life and adequate health care.

So that is what this is about and I thank you for being with us. Good luck in Sacramento.

Mr. CANNELLA. Thank you. If we only had 4 more months.

Mrs. BOXER. This year.

I would like to call the first panel, The CEO of Scenic General Hospital, Beverly M. Finley and colleague, Solange Goncalves Altman of the California Rural Legal Assistance and Dr. John C. Pfeffer, President of the Stanislaus Medical Society.

What I am going to ask you to do is keep your comments to about 5 minutes. After 5 minutes if you haven't finished, just relax and talk for 5 minutes and we will move on because we have to move forward and I want to be able to have time to ask you all questions. So why don't we start with Ms. Finley.

STATEMENT OF BEVERLY M. FINLEY, CHIEF EXECUTIVE OFFICER, SCENIC GENERAL HOSPITAL, MODESTO, CA

Ms. FINLEY. Good morning. Madam Chairwoman, I am Beverly Finley, Chief Executive Officer of Scenic General Hospital, Modesto, CA. It is an honor to be here today to represent Scenic General Hospital and the county of Stanislaus' health care system on the subject of the Health Care Crisis: Problems of Cost and Access.

Scenic General Hospital is a 134 hospital, owned by Stanislaus County that has served the community for a century. From its beginning, Scenic has been charged with a mission of providing care for those who cannot afford to pay. The hospital provides a whole complement of services with the exception of labor and delivery and neurosurgery.

Outpatient clinics which are located both on the hospital's main campus plus two satellite clinics care for over 130,000 patients each year. Ninety-five percent of our patients are insured under Government sponsored programs. There is no room for cost shifting within this payer mix.

Scenic General Hospital is proud to be affiliated with the University of California at Davis, Family Practice Residency Program with a total of 21 family practice residents. The residents receive their training from a hospital-based faculty group of 16 physicians plus the part-time assistance of 45 community physicians. Forty percent of the program's graduates have remained in the Modesto community expanding access to medical care for the residents of the county.

The problems facing Stanislaus County and its health care system reflect the long history of a budget-driven health care policy at the State and national levels that has eroded access to indigent patients. Despite years of declining margins produced by Medicare and Medi-Cal shortfalls, increased demand, increased costs and inflation, an eroding physical plant and capital equipment base, the Stanislaus County health care system, including mental and public health care services, has been able to maintain its commitment to provide high quality care to its patients.

However, the struggle has reached crisis proportions. The proposed reductions in the fiscal year 1991 Federal budget proposal, if enacted, will escalate this crisis. The gap between revenues and expenses cannot continue to widen without dire consequences to access for all of us.

With the proposed Medicare cuts, teaching hospitals will be hardest hit. Teaching hospitals tend to serve more acutely ill patients as is typical of the low income and indigent population. In the past,

teaching facilities had a higher than average Medicare reimbursement which was based upon the adjustments which recognized additional costs associated with a teaching program.

This trend no longer holds true since the reductions in Federal support covering medical education cost continues to be reduced and the proposed 25-percent cut in allowance for capital payments.

Paying hospitals less than the full cost of a training program or the full cost of capital is not a sound public policy. The Nation will continue to require an increased number of medical professionals. The improved technology is an investment that actually results in lowering the cost of health care.

It is now possible to have gall bladder surgery on an outpatient basis through innovative techniques eliminating the need for lengthy hospital stays. This technology must be available in teaching programs for the future needs of all citizens. Refusing to recognize the value of investing in medical education is an impractical approach that will have far reaching effects in terms of economics and standards of care.

Likewise, the proposed 10-percent reduction in Medicare outpatient reimbursement is especially alarming. Hospitals have responded to the need to reduce costs by moving patient care to outpatient settings when appropriate. To further reduce inadequate reimbursement for outpatient care will place Medicare patients in the same dilemma now facing Medi-Cal patients, which is, access will be restricted or denied.

In theory, Medi-Cal patients in Stanislaus County can seek care from any provider whether hospital or physician. In practice this is not true. The low reimbursement level coupled with cumbersome billing requirements have gradually excluded nearly all private physicians in Stanislaus County from accepting Medi-Cal patients.

Furthermore, because of the litigation process and increased costs, many physicians have stopped treating OB, reducing the number of providers available for this service.

Scenic General Hospital and other hospital emergency rooms have become the safety net for Medi-Cal patients. The availability of subspecialty physicians to see a Medi-Cal or indigent patient at Scenic is increasingly difficult to secure because of inadequate reimbursement.

The ramification of this poor reimbursement on access to Medi-Cal patients is dramatically illustrated by the obstetrical service provided at Scenic.

In 1982 Scenic's OB services performed an average of 88 deliveries per month; and in 1989, 157 deliveries a month. Current data projects 300 deliveries per month by 1995. The number of high risk prenatal visits has increased over 50 percent during 1989. Much of this increase is directly attributable to the decrease in the number of providers who are willing to accept Medi-Cal patients into their private practice.

Scenic's capacity to accommodate this increased volume is restricted by its aging physical plant. Existing space constraints prohibit the expansion of OB clinics to accommodate the increased demands for women seeking OB care. During this time Scenic has lost the only full-time OB/GYN on its hospital-based staff, exacerbating the problem of access.

After long and difficult debate concerning the need to limit access to ensure quality of care, the coordinator of OB services, Dr. Jesse Wilmes, began to set limits on the number of new patients that could be accepted into the clinics. Because of the excess demand, appointments could not be given prior to the delivery date for many women.

During this time Dr. Wilmes was aided by Dr. John Pfeffer, President of the Stanislaus Medical Society, who participates in the residency teaching program. Because of the leadership of Drs. Wilmes and Pfeffer, a coalition with the community OB/GYNS was formed to accommodate the needs of pregnant women who cannot get realistic appointments into the Scenic OB clinics.

Physicians have agreed to accept two to three Medi-Cal patients into their private practice on a rotation basis assuring the mother of prenatal care. The scheduling of these patients is performed by our Public Health Department. This program began August 1.

The OB clinic is only one example of the problems of access for indigent and Medi-Cal patients in the County. The pediatric clinics have a 3-week waiting time for appointments, not a satisfactory delay when you have a sick child.

A 48-day wait is necessary for a neurology appointment. Dermatology patients may wait for 3 months. Appointments in the residents' clinics average a 3-week wait. These waiting times are present in clinics that are exceeding capacity as much as 145 percent for OB and 190 percent for surgery.

The delays in getting appointments and long waiting times to be treated on the day of the appointment result in frustration for patients. No show rates approach 30 percent as patients seek treatment in the emergency rooms of local hospitals as they are not willing to wait.

Not only patients become upset. Hospital employees face daily frustration with angry patients, either those who have waited a long time to get in to see the doctor or who cannot get an appointment when they pursue health care needs.

As a safety net hospital, Scenic has treated all patients who seek care through its services. However, our future looks bleak. The community need has already exceeded this county hospital's resources as evidenced by limiting access for prenatal care.

Scenic has not experienced an operating margin that has allowed for physical plant replacement or renovation.

The Medi-Cal reimbursement rate to Scenic General Hospital is less than 50 percent. We will have lost $1.8 million last year on outpatient services and yet the State continues to decrease its reimbursement.

I would like to just summarize the rest of my talk and state that on Friday we had a balanced budget. On a Monday we had a deficit of $2.4 million. The results of a budget-driven health care policy is making planning impossible.

Those programs that we could generate additional revenues with are defeated before we can get them operational because we don't have either seed money or the moneys we had planned to spend. To not allow us to use tobacco tax money or AB8 momeys to plan from one year to the next is a travesty of the intent of the legislation. The mandate to spend the money in a 4-month period is insane.

The noose of low reimbursement is restricting care for patient care. The low reimbursement and reduced allocations place us, as well as the rest of the county health care system in dire need of new funding. It is clear that we need access to a new source of revenue.

If Scenic cannot recruit and maintain staff or address its needs for competitive salaries; if Scenic is not able to expand its purchasing power to acquire capital equipment replacement; and if Scenic cannot expand its revenue base to cover debt service to replace its aging plant, the safety net to indigent and Government-sponsored patients will be so constricted that access will be delayed not for hours but weeks and months. Thank you very much for hearing us.

[The prepared statement of Ms. Finley may be found at the end of the hearing.]

Mrs. BOXER. Thank you. I think you have really painted a very bleak picture of what is happening here in this community.

Ms. FINLEY. It is our reality.

Mrs. BOXER. Any questions from the panel?

[No response.]

Mrs. BOXER. Solange Goncalves Altman, please.

STATEMENT OF SOLANGE GONCALVES ALTMAN, STAFF ATTORNEY, CALIFORNIA RURAL LEGAL ASSISTANCE, MODESTO, CA

Ms. GONCALVES ALTMAN. My name is Solange Goncalves Altman and I would like to thank you for inviting me to speak to you today.

I am a staff attorney with California Legal Assistance here in Modesto. CRLA is a federally funded legal services program with 15 offices throughout rural communities in the State. We are actively involved in health advocacy for rural poor people.

Most recently we were involved in a community effort to keep this county's hospital, Scenic General Hospital, open. Closure was threatened only last year.

As a legal services attorney, I have witnessed firsthand the problems of cost and access faced by many low and middle income people. I have assisted clients in actually obtaining medical care, in challenging erroneous Medi-Cal determinations to obtain benefits, and in arranging payment schedules on bills which will not be paid in your lifetime or mine.

Of the dozens of clients I have represented, I believe the experiences of Terry Brogdon, Pam Cobb and Erma Stepp exemplify the access problems to orthopedic, obstetric and dental care experienced by poor people in this county and in this State.

In August 1988, Terry Brogdon suffered a knee injury while working at his job as a drywall hanger. He thought his employer had Worker's Compensation which would cover his medical care and compensate him for his period of disability, but this was his first mistake. He soon learned that his employer had no Worker's Compensation and that he might never be compensated for his injury from the Uninsured Employers Fund.

Terry had no difficulty in getting treatment for his knee from a private orthopedist while the doctor thought that Worker's Com-

pensation would pay for the bills. By the time surgery was scheduled, it was clear there was no Worker's Compensation.

Unable to work because of his knee, Terry and his family applied and were granted public assistance and Medi-Cal. Terry offered to pay the doctor for the surgery with his Medi-Cal, but the doctor wouldn't accept it.

In March 1989, Terry attempted to get an appointment at the county hospital, but he was told that new Medi-Cal patients were not being accepted, only patients under the Stanislaus County Indigent Health Program. Under that county program, services are provided exclusively at the county hospital.

Scenic was forced to cut back orthopedic appointments then because one of their orthopedists was out on sick leave and as hard as they tried they had not found a replacement. Medi-Cal patients were turned away because it was erroneously assumed that private orthopedists in the community would accept Medi-Cal.

In late March, Terry came to see me. I called every orthopedist listed in the telephone book, inquiring whether Medi-Cal was accepted. Finally, one office in Turlock scheduled Terry for an appointment, but when he arrived for the appointment he was told that new Medi-Cal patients were not being accepted.

Unable to find an orthopedist in Stanislaus County, an appointment was made for Terry at San Joaquin General, in Stockton, the county hospital there, which is about 35 miles from Modesto. Though Terry felt it would be difficult to travel there for treatment, he was determined to get the care he needed.

Shortly after this appointment was made, I learned of a new orthopedist in Modesto, who had not been included in the specialist listing in the telephone book. This orthopedist was on contract at Scenic 1 day a week, and he agreed to see Terry at Scenic the first week of June. He ultimately performed surgery on Terry's knee in late July and Terry was released for work in September 1989, a year after his injury.

Terry's time off work cost the taxpayers approximately $7,200 in cash aid. It was only as a last resort that his family was forced onto public assistance. Being on public assistance was both a humiliating and humbling experience for him. His family is keenly aware how a medical emergency could force a middle class family on the public dole.

While Terry Brogdon was able to get the medical care he needed, it was only because of his and my persistence, and because he was lucky enough to have found a private orthopedist who would care for him. Other indigent requiring the services of specialists such as obstetricians have not been as fortunate.

Pregnant women are among those who have had a particularly difficult time in obtaining maternity care because of the paucity of obstetrician/gynecologists who will take Medi-Cal. In May, Scenic General became overloaded and 10 pregnant women like Pam Cobb were turned away per week. Pam tried to find a private obstetrician to take care of her with no success.

In Stanislaus County, the number of family practice physicians serving more than five Medi-Cal patients dropped from five to three in 1985. State statistics reveal the shortage of obstetricians who take Medi-Cal is extremely critical.

From 1985 to 1987 there was a sharp decline in the number of obstetricians and family practitioners in private practice who were willing to provide maternity care to women on Medi-Cal. One study found that 3 out of 10 practicing obstetricians in California participated in the Medi-Cal program to the extent that the State paid for 10 percent or more of the deliveries in their practice. Meanwhile, women on Medi-Cal have been giving birth to approximately 25 percent of all children born in California each year.

With limited access to obstetricians and family practice physicians, many poor women forgo prenatal care. According to the California Department of Health Services' most recent report—for calendar year 1984—only 61.3 percent of the women on Medi-Cal received any prenatal care during the first trimester. Stated differently, over 40,000 women on Medi-Cal were receiving no maternity care during the critical first 3 months of pregnancy.

The lack of prenatal care has translated into more high risk pregnancies and a higher infant mortality rate. According to a Children's Research Institute Study, high risk pregnancies constituted one of every five births in California in 1984. California ranked 14th in the Nation in preventing infant deaths with an infant mortality rate of 9.4 percent per 1,000 live births in 1983. In 1985, Stanislaus and Merced ranked at the bottom of the county infant mortality list.

In this county, a solution to the plight of pregnant women was found when 23 of the 24 private obstetricians in Stanislaus County each agreed to take up to three Medi-Cal patients per month for prenatal care to alleviate the crisis. To get this participation from private providers was an exemplary achievement—a credit to the leadership of Scenic General Hospital and the Stanislaus County Medical Society.

These 23 private obstetricians taking Medi-Cal patients will help resolve the access problems faced by poor pregnant women in Stanislaus County in the short run. The concern I have is how long their assistance can be counted upon. For how long can we expect them to provide the extensive care high risk pregnant women require when they are paid a flat fee of $1,010 by Medi-Cal for all prenatal care including vaginal delivery.

Mrs. BOXER. Can I ask you a question? What is the average fee of the physician?

Ms. GONCALVES ALTMAN. For a vaginal or a caesarean? It varies?

Mrs. BOXER. For——

Ms. GONCALVES ALTMAN. Actually, Dr. Pfeffer can answer that better than I can.

Dr. PFEFFER. Locally, it is probably somewhere between $1,650 and $1,800 for a vaginal. In San Francisco it is around $2,400, is my understanding. A caesarean would be an average of $500 more.

Mrs. BOXER. Thank you. I didn't mean to interrupt you.

Ms. GONCALVES ALTMAN. Though the $1,010 Medi-Cal reimbursement rate for vaginal deliveries appears incredibly low, the rate was only $650 in 1987. The rate was increased because of *Clark* v. *Kizer,* a lawsuit filed by legal services advocates.

Though the challenge to the Medi-Cal reimbursement rates for obstetrical care has been settled, the dental component of that lawsuit has not.

The lack of dentists who will accept Medi-Cal, sometimes known as Denti-Cal, has created another tremendous access problem for poor people. Erma Stepp is an 81-year-old client of my office who suffered enormously because of her inability to get proper dental care.

Mrs. Stepp, a diabetic, needed a partial lower denture, which was not an appliance covered by Medi-Cal regulations. Her need for the appliance was legally challenged as medically necessary because she could not eat without it.

After litigation, Medi-Cal agreed to pay for the appliance, but even with Medi-Cal, Mrs. Stepp encountered much difficulty in acquiring the appliance because so few dentists accepted Medi-Cal. Most dentists charge $1,000 for a partial lower denture, but Medi-Cal only pays $289. Even so, after much effort, one dentists in Stanislaus County was found who would make the appliance for her.

Provider participation in the dental program is also extremely low.

Four out of 10 dentists in California refuse to treat any Medi-Cal recipients. Only 1 in 10 dentists draw more than 10 percent of their patients from Medi-Cal recipients. As a consequence, only one in five children on Medi-Cal receive routine preventive dental care each year; the statistics are even worse for adults.

As with obstetrics and orthopedics, low provider participation is a reflection of the absurdly inadequate reimbursement rates. In some instances the rates will not even cover the cost of materials, let alone the dentist's labor and malpractice premium.

In the three living examples provided of health access problems there are some recurring themes: (1) Private providers don't want Medi-Cal patients because Medi-Cal reimburses them inadequately or not at all; (2) county hospitals like Scenic General Hospital are bursting at the seams. They have been expected to act as the safety net for patients who can't get treatment anywhere else; and (3) the longer medical care is delayed the more expensive it is to the taxpayer because medical expenses will be greater for more complicated conditions or because unemployability forces medically needy people to seek public assistance.

For the past 10 years there has been little Federal leadership in attempting to come to grips with these problems. For the past 8 years there has been virtually no State leadership as well.

To the contrary, more and more of the financial burden has been put on the backs of local government which lacks the tax base to provide meaningful solutions. It is time for some leadership. State and Federal health care policies must change in several respects. Some of the changes that would improve health access would be:

(1) The improvement of provider participation through increased Medicaid/Medi-Cal reimbursement rates, loan forgiveness and indemnity programs.

(2) Funding priority must be given to prevention services, and by prevention services I mean support for programs like Women, Infants and Children which provide food for low-income women, women with small children, nursing mothers. That is a program that was cut dramatically by the Federal Government.

(3) In addition, financial support must be given for expanded clinical services. The real problem is when you don't have access to a doctor on a regular basis you don't get preventive care. It is especially obvious with the pregnant women. When they can't get in for prenatal care, they suffer more problems.

So, if facilities like Scenic or the Modesto Family Health Clinic had their services expanded so they could see more people for regularly scheduled appointments for routine care, I think you would see a dramatic drop in the number of high risk patients and it would be less expensive to care for people because they wouldn't be faced with problems that they are faced with.

Those are my three main points.

Mrs. BOXER. You have one more.

Ms. GONCALVES ALTMAN. Excuse me, and the fourth point was universal health care coverage, which is perhaps the most important one. I know that Congress recently had the Pepper Commission submit a report to you and I am not that familiar with what the report says and what they are advocating in terms of that universal coverage.

In California there is a bill that is pending by Senator Petris which provides universal access and it is modeled after the system in place in British Columbia.

Legal services advocates are supporting that legislation, only because there is the feeling that it alone really tackles the problem of providing medical coverage for 6 million uninsured people in California. And those are my four suggestions.

[The prepared statement of Ms. Goncalves Altman may be found at the end of the hearing.]

Mrs. BOXER. Thank you. Thank you very much. Dr. Pfeffer.

STATEMENT OF JOHN C. PFEFFER, M.D., PRESIDENT, STANISLAUS MEDI-CAL SOCIETY, MODESTO, CA

Dr. PFEFFER. Madam Chairwoman, I am John Pfeffer, president of the Stanislaus medical Society and a practicing Obstetrician/Gynecologist in Modesto. It is a privilege and an honor to be here today to represent the Stanislaus Medical Society.

I appreciate the opportunity to testify before the House Budget Committee Task Force and I appreciate further your personal interests and efforts in this area.

The general tone and setting of the medical community in Stanislaus County has previously been described to you in the other testimony presented today. The general problem of access to care an funding of same has been discussed as well. I will limit my comments to the special problem of access to perinatal care, recognizing that this is representative of the problem at large.

The issue of access to care as it relates to obstetrical and perinatal services in our country has reached crisis proportions. Our county facility, Scenic General Hospital, has had to limit access to care for obstetrical patients because of a tremendous shortage of manpower, space limitations and a desire to provide excellent care to fewer patients rather than to provide substandard care to many.

One of the major issues regarding access to care in our county is the growing numbers of patients who are either dependent upon the State to be a third party payer, that is, Medi-Cal, the truly medically indigent patients or the working poor, who are unable to afford insurance yet not poor enough to qualify for State or Federal assistance. As a result, these segments of the population cannot afford private obstetrical care.

There are many reasons as to why a crisis has been reached with respect to access in our county. Many local obstetrical practices are closed due to their busy practices, regardless of the type of insurance coverage. In addition, several practitioners have discontinued delivering obstetrical services within the last year altogether.

Furthermore, the economics of accepting these patients into a private practice are such that it is a situation of a negative cash flow and as such, private practitioners are reluctant to accept large numbers of such patients into their care.

Recent data has demonstrated that 62 percent of all physicians statewide provide services free or at reduced fees for patients in need. This activity accounts for 11 percent of their weekly practice hours.

Because of the increased numbers of such patients, combined with poor reimbursement and increased bureaucratic demands, providers of such care can no longer absorb the cost. In 1985, it was estimated that in San Francisco, each physician wrote off $51,000 per year as uncompensated care.

In addition, there was an average of $32,000 per year which was discounted from the usual fees by Government insurance programs.

Certainly these numbers are significantly higher today. Because of bureaucratic problems, such as a suspension of files or denial of claims that are rampant within our present system, all under the guise of accountability, it has made it distasteful and unprofitable for private practitioners to provide these services.

I am sure that the number of physicians caring for such patients as well as the percentage of such patients allowed into their practices will diminish inversely as the paperwork and obstacles increase.

Because of the genuine concern that the physicians in Stanislaus County have had for the welfare of their patients, as well as the concern for the significant increases in maternal and neonatal morbidity and mortality associated with attending patients with no prenatal care and because of the litigation crisis that is present for all high risk medical specialties at this time, the practicing obstetricians in Stanislaus County have reached a consensus to formulate a plan of 1 year's duration to provide care for these patients within the private community.

Because of the physical and economic hardships that this presents to the individual practitioners however, this will only be a temporary solution to a long-term problem.

It does, however, afford us a window of opportunity to be able to establish a setting that will enable us to provide adequate prenatal and obstetrical services to these patients, while seeking a long-term solution to this most pressing problem.

Our obstetrical referral project represents a unique marriage of interest between the Stanislaus County Department of Health and the Stanislaus Medical Society. Each month the Department of Health Service will provide a link between obstetrical patients who are qualified for Medi-Cal and a practicing obstetrician in the private sector who will provide prenatal care and delivery services for these individual patients.

As this program has just started August 1, 1990, exact numbers are not available. It is, however, estimated that approximately 80

to 100 women per month in Stanislaus County are now delivering their children without prenatal care through local emergency rooms and obstetrical units.

Stanislaus County and the Stanislaus Medical Society have updated their list of physicians who are willing to accept several additional Medi-Cal patients per month to provide appropriate care.

Following the delivery of obstetrical and postpartum care, these patients will return to the county health system for their continuing health care.

Stanislaus County is proud of our tradition of volunteerism, social consciousness and public spiritedness. We are optimistic that our current efforts will not go unnoticed and will, in fact, improve perinatal care within the community.

We are deeply concerned, however, that over the next several years this care will be limited because of the increasing patient populations which are unable to obtain adequate insurance coverage, the increasing population shift to our rural communities, and, coupled with the decreasing reimbursement, physicians will be reluctant to continue working for less than the cost of their overhead.

Additionally, it is becoming increasingly more difficult to entice physicians to continue their practices in obstetrics given the socioeconomic scenario currently present and the litigation crisis constantly rearing its ugly head.

In brief, there appear to be several major obstacles to providing appropriate prenatal services in our county. First of all is the liability crisis which I believe is directly responsible for the decreasing number of physicians willing to provide obstetrical services.

Second, the underpayment of services rendered, often at less than overhead, make it economically unfeasible for physicians to provide such services.

Third, the increased burden of cumbersome paperwork and lengthy appeals to billing suspensions and denials make the whole effort unrewarding and not worthwhile.

Fourth, the major societal problems of substance abuse, particularly as they relate to narcotics and alcohol addiction, compound the already high risk population who have not accessed themselves to prenatal care, leading to increased risk to the mother and child medically, and legally to the physical rendering care.

Fifth, there is the constant problem of educating the public as to the benefits of providing prenatal care. Some women simply don't seek prenatal care, even when it is available to them.

The solutions to these problems are complex and varied. Several factors must come into play.

(1) Reimbursement for care rendered must be increased to appropriate levels. The usual Medi-Cal rate, varying between 35 and 47 percent of the usual and customary charges, are below that often needed to cover the office overhead.

The recent decision to reimburse all obstetrical services at universal rates with global fee, regardless of the risks encountered, the skill necessary or the work done has further reduced this percentage.

The Medi-Cal reimbursement for a surgical assistant on a cesarean section is so abhorrently low—$60—that it is increasingly difficult to find physicians willing to render such assistance.

Additionally, pediatric and anesthesia services are more severely underpaid or simply are not reimbursed. The pediatrician at a cesarean section, I believe, is paid $12. Therefore, certain services are not available to these patients and procuring appropriate pediatric care is increasingly more difficult to obtain.

Mrs. BOXER. If you call in a pediatrician——

Dr. PFEFFER. If I have to call a pediatrician to attend a Medi-Cal cesarean delivery at 3 in the morning, my understanding is they get reimbursed $12 for that.

If the physicians providing care cannot meet their cost and afford a small margin of profitability, the majority of us will simply not render this care in addition to the "tithing" that we are already providing.

A reduction in the bureaucratic demands and expenses is a must in order to make the care affordable to the State. This will allow the physician the opportunity to practice medicine in relative ease without the excess burden of paperwork that is often duplicated, confusing and cumbersome.

Recent estimates have shown that independent of the cost of patient care, the cost of running the American payment system may account for more than half the difference in cost between the Canadian and the U.S. health systems.

The litigation crisis needs to be addressed in a more effective manner by the legislature. Certainly, we would be most pleased with support of Senator Hatch's proposal of establishing, in a sense, a Federal MICRA.

In this regard, a major Harvard University study of malpractice in New York hospitals recently noted that over 80 percent of the cases filed by lawyers involved no negligence.

In other words over 80 percent of the patients who sued had no basis for doing so. Additionally, the most striking statistic in the study was that 99 percent of the patients received treatment without any negligence occurring.

A 1-percent rate of negligence, I believe, is a statistic to be proud of. I can think of no other profession in the country that can boast such an outstanding record.

Currently the county hospital is our safety net. I would add one final plea to maintain appropriate reimbursement to the counties for the continued staffing of these facilities.

Increased reduction in the reimbursement to the hospitals eventually translates to a loss of the safety net with an inability to maintain the level of care, the staffing personnel and the physical plant that are required to stay competitive in today's medical environment.

Seed money is needed to help establish CPSP clinics and the like that will continue to allow us to extend care to these patients in a preventive manner, one that has been shown to be efficacious with respect to medical economics, decreasing morbidity, mortality, and expenditures.

I believe there must be change in the public philosophy such that access to care truly relates to a privilege and not a right in our so-

ciety. I do believe that the society has a duty to care for these patients, but not at the extreme cost to the taxpayer.

In our country we have been fortunate enough to have leadership, the wisdom and the beneficence of the local physicians that will allow us to search for solution to the serious problems confronting us. The assistance of you and your colleagues is desperately needed and most welcome.

We have allowed a window of 1 year, in our community, to find some permanent solutions. I hope that we can.

Thank you for allowing me to present these comments to you today.

[The prepared statement of Dr. Pfeffer may be found at the end of the hearing.]

Mrs. BOXER. Thank you, doctor. I must say this panel has been terrific. I have some questions for you but before I get to those I would like to say that I am very pleased we have in the audience two gentlemen who are not on the panel but just having them here says a lot for their concern. Doug Dent, the administrator of Merced Medical Center, Dan Sepponeri who is administrator of Evergreen Convalescent Hospital. Thank you for being here.

I also see Perry Richard, Director of Public Health and Larry Poster, Director of Medical Health is here also. We are very pleased that you can all be here today.

By the way, I have a special setup where we are going to leave the record open for 2 weeks, so if there is anyone in the audience who would like to get their comments into the record of this hearing, just talk to Lynne Richardson, Task Force Director and get her card.

I have so many questions but I will try to be concise. First of all, Ms. Goncalves Altman, you by way of showing us some interesting examples, gave me a very clear view of what is happening which I want to take the case of the individual with the knee injury who was a working person who had no health insurance at his job but thought he was covered by Worker's Compensation? Is that the——

Ms. GONCALVES ALTMAN. Well, he should have been covered by Worker's Compensation. The employer hadn't taken it out and covered him.

Mrs. BOXER. And he also wasn't covered by any health insurance.

Ms. GONCALVES ALTMAN. No.

Mrs. BOXER. It was one of those uninsured workingmen.

Ms. GONCALVES ALTMAN. Right, but he was injured on the job so if the employer had had Worker's Compensation——

Mrs. BOXER. I understand, but the employer never paid health insurance for him.

Ms. GONCALVES ALTMAN. No.

Mrs. BOXER. Nor did the employer have Worker's Comp.

Ms. GONCALVES ALTMAN. Right.

Mrs. BOXER. Which is a very despicable set of circumstances when you are in the construction industry. So here is someone who should have gotten health care because he was injured working on the job, didn't, and because of circumstances, couldn't find a doctor to take Medi-Cal, which is understandable considering what we are looking at, and couldn't go to the hospital because of the circum-

stances beyond their control, and so for a year couldn't get medical care.

And so there are many who are just not getting medical care. But this is a person who just has no insurance and I guess I want to ask Ms. Finley this question.

We have a county hospital and essentially we were under the impression that everyone has insurance—more people do have insurance than do not and at least we didn't know about too many people who didn't have insurance and the problems that went on. So the notion of our county hospital was, if you were uninsured, you went to the county hospital.

So now it is like you have a huge burden because you are taking Medi-Cal patients who are getting turned away from private practice for reimbursement reasons, you are getting people with no health insurance. What do you do with them when they come in?

Ms. FINLEY. We continue to treat everyone but, of course, that just exacerbates the situation.

Mrs. BOXER. Do you get zero or do you do a sliding scale?

Ms. FINLEY. Well, we do try to get them on the indigent health care programs and that is basically the males that do not qualify for Medi-Cal. Many of those are working adults.

At the same time, that is the exact fund that we had in the last 18 months a $1.3 million cut in and it is our plan at the moment, or our expectation, rather, that the next budget cycle in Sacramento will take away the remaining $3.2 million.

And so they are putting us greatly as risk for that uninsured, underinsured population and we really just plain don't have the capacity, either physically or providers, to meet the need.

Mrs. BOXER. What if somebody comes in and they have no health insurance. They work, let's say, a minimum wage job or a little above and they have some assets. When they come in—they have to come in because they have some injury that if they don't fix they could no longer work.

What do you do? You don't take away your last dollar, do you?

Ms. FINLEY. No, no, we don't do that. There is a financial screen. We try to get them qualified for any program that exists and if they don't, they are considered a personal pay, if they have assets greater than the screens. And the reality is, we usually don't get paid.

Mrs. BOXER. Let me just go through this. You take care of the people who are the working poor without any insurance. You take care of the Medi-Cal people that get turned away from the private sector and do you have regular paying patients with insurance?

Ms. FINLEY. It gets increasingly less and, of course, just as you pointed out, the tradition of county hospital is perceived to be uncompensated or unemployed people and of course with the failing physical plant, how can we compete with programs that have high marketing and high capital improvement budgets.

Mrs. BOXER. How about the Medicare part? Do you have representative——

Ms. FINLEY. Well, frankly, we are prevented with treating a lot of Medicare patients because the private hospitals all have programs that forgive the deductible for their Medicare patients which we are not allowed to do. That is considered a gift of county funds

so we can't advertise that we will take everybody and it won't cost them anything.

That is in spite of the fact that every one of our doctors takes assignment, which is very unusual in the community, and yet we can't advertise because we don't forgive the deductible.

Mrs. BOXER. So that I understand, you can't compete for the patients, essentially, that pay their way or at least——

Ms. FINLEY. That have options, right.

Mrs. BOXER. So you are predominantly dealing with those people who don't pay their way and you are struggling over this.

Ms. FINLEY. Absolutely.

Mrs. BOXER. What would happen—and the first thing I want to say is I am so happy to see my best friend from Mississippi, one of the great Members of Congress, a really wonderful voice from the south for people programs for children, for health care, he sits on this Task Force.

And we have problems here this morning because the Medi-Cal program, which is Medicaid here, so under-reimburses that the county hospital that takes care of these people is overburdened with these cases and that is about what we have heard.

Mr. ESPY. Thank you.

Mrs. BOXER. What would happen if this hospital closed, Dr. Pfeffer?

Dr. PFEFFER. We would have a lot of problems. We really would have a disaster. The number of patients that are cared for there would present themselves to the private hospital emergency rooms which by law would have to provide for those patients.

Those hospitals are three or four in the county, but two in the city, and really are overburdened. They don't have room. The operating room for elective cases, sometimes this summer, have been working 24 hours per day. There simply are no beds.

We have patients who have, in both of these hospitals, spent the night in the recovery room because there are no beds to put them anywhere and closing this facility would aggravate that.

Economically, I am sure it would be very hard for the hospitals to provide care for many of the patients who are there a long time with serious problems with little to no reimbursement.

The facilities just aren't large enough to handle the load.

Mrs. BOXER. Ms. Goncalves Altman.

Ms. GONCALVES ALTMAN. When the closure was threatened last year there was a blue ribbon committee that was appointed—actually, Ms. Finley was on it—and a study was done by Arthur Young. And one of the things that they looked at was what the impact would be to the community.

And I don't recall the figures specifically, maybe Ms. Finley does, but what they indicated was that the private hospitals in the county did have the capacity to absorb the inpatients from Scenic but there was no way that those emergency rooms could handle all of the outpatient visits from Scenic.

And the real problem would be that people wouldn't be able to go anywhere, really, for that preventive routine care and there would be more and more of a burden on those private facilities on their emergency rooms which are already burdened.

Mrs. BOXER. I want to compliment you on this program you worked out where the OB/Gyn agreed that there would be three Medi-Cal patients—new patients—taken every month. Is that correct?

Dr. PFEFFER. Yes, basically what we have done is I was able to convince most of the obstetricians in town to participate and what will happen, on a rotational basis the county people take as many people as they can handle and above that the patients will be distributed to the local obstetricians.

Now we only agreed to do that for 1 year, though, because the one physician who elected not to participate said that, "Well, why should I do that when I am turning away private insurance patients? We are all overloaded."

In this community we have had a number of people retire. We have had a couple replacements come in. All the family practitioners except a handful have gotten out of the obstetrical business because of the litigation crisis. So we have fewer providers than we had before with the population expanding.

They have agreed to do this for 1 year with the understanding that that gives us 1 year to try to find a permanent solution. That is a very arduous task.

At the end of the year I think that most of the private physicians will back out of this because it simply is not profitable and to be honest I think that one of the problems that we see with Medi-Cal we are beginning to see with the private insurance companies.

One of the former presidents of the Los Angeles County Medical Society did a study a number of years ago looking at where the dollars went and it was very interesting. For every dollar spent on Medi-Cal, 50 percent went to administration of the program.

And we see that happening more and more in the private insurance companies also. The cost of medical care, in large part, is not due to the physician's fees going up. It is due to the bureaucratic fees and demands going up, what I think is under the guise of accountability, particularly when you look at the study that I commented on, where there is a 1-percent mismanagement rate.

If we are spending 50 percent of our dollars to look after that 1 percent, our dollars are going the wrong place. We simply have fewer providers at lower reimbursement.

The first several months of this year, the assistant at a cesarean section was paid exactly the same as the assistant at a vaginal delivery and it took someone in Sacramento 4 months to figure out that there was no assistant at a vaginal delivery, so the assistant didn't get paid.

You can't find assistants to come in and provide care when they don't get paid.

Mrs. BOXER. Who sets these Medi-Cal reimbursement levels?

Dr. PFEFFER. Someone with wisdom in Sacramento, I guess.

Mrs. BOXER. I want to thank this panel very much. You have educated me, and I am very clear about the kind of burdens you are seeing and where the downfalls are and they are right here at your doorstep and you are dealing with them and while President Bush still talks about building star wars, the cold war is over, as I understand it, and that is really the battlefield for us when we go back.

Because with this crisis in the Middle East, I hope it won't give people an excuse to say, "Well, we have to be prepared for a crisis." And of course it is a challenge and we need different types of responses but not the same nuclear weapons and that is the kind of argument that we get into.

Thank you very much to this panel and Mr. Espy, thank you for joining us today.

I would like to say you have been a real bright light in Congress, reaching out and working on so many issues. So why don't I turn it over to you to provide us with an opening statement for anything you would like to say.

Mr. ESPY. I would simply like to welcome you here today. It is so important that someone pay attention to the rural areas and the central areas in terms of health care and we appreciate the fact that you are here and were present yesterday and we have some real concerns with situations with rural health care here.

And it is important for us to collect the information and take it back so we can make some intelligent decisions as to health care in rural areas. And I know you worry about Medicare and we have heard about rural hospitals. One of the areas of concern for us as the meeting goes on today is the fact of personnel, recruitment of personnel.

Once again, rural areas have a difficult time keeping physicians and nurses and the health care people in the area because they can go elsewhere and make more money and that is difficult. So that is one of the areas that I know a lot of people in the Central Valley and especially in the west are interested in and maybe as we go on here today we will hear some of that.

I would like to thank you, Mrs. Boxer for holding this hearing and all the others that you set up as Chairperson of the Task Force for Human Resources.

And through the many months that you have chaired this Task Force you have heard about problems with Medicare, AIDS, biochemical research, dental and health care and, of course, a program close to my heart, the WIC program.

I come today to Modesto from the delta of Mississippi which many would call the third world within the United States of America. So really what I am talking about are third world statistics. Places like Humphrey's, MS, where out of 1,000 babies born, about 33 of them won't live.

So in Mississippi, we have some of the same problems that you have here, not enough physicians, patients falling through the cracks and left without health insurance or left without any sufficient health insurance.

In Mississippi about 760,000 people, or 30 percent of the entire State, are people there without any health insurance. However, 52 of our 82 counties are health net power shortage areas. Fourteen hospitals have closed since 1985.

Besides being a Mississippian, I have the honor to serve on the House Budget Committee and Congresswoman Boxer's Task Force. By coming to this hearing today, I hope to learn more about the specific health care dilemma. With the information that we gather here we will go back to Washington, as Mr. Condit already said, and share it with our colleagues and use this information as am-

munition. The ammunition we need is to convince our colleagues that we must place a priority on health care and when I say a priority, I don't mean just allocating more money, but rather allocating more time to solving these problems with more concern and more money.

I share Mrs. Boxer's concern also about some of those who might wish to use the crisis in the Middle East and the Persian Gulf with increasing money to defense allocations. I say, as she already said, I still don't think we need more nuclear bombs and I don't think a strong defense has to be that.

Over the past year we have had proposals to increase access to health care in both the House and the Senate. We passed a reauthorization of the National Health Service Corps. With this bill we have revitalized the scholarship program and increased the maximum amount of loan repayment to $30,000.

We are also working on the Medicare reimbursement for nursing, the Medicare reimbursement for physician services. All of these are proposals that are aimed at getting health care to the areas that are most neglected.

As Mrs. Boxer indicated, we are aware of our budget crunch. If we allow sequestration to kick in, on October 1, we will lose about 7,000 National Institute of Health grants, approximately $69 million will be cut from our funds for providing health care to veterans and AIDS funds will be reduced by about $55 million.

And that is just some of the minor effects of sequestration. We must bring the information that we get from these hearings back to Washington so that we can negotiate before sequestration and these cuts will not impact the program. So, again, I will thank you for allowing me to be here.

Mrs. BOXER. Thank you, Congressman. I want to respond briefly to what both of you said. As Congressman Espy describes, I was really amazed yesterday at the crisis we are facing in our rural health care.

I mean, a prediction by a doctor from Children's Hospital there that in several years 50 percent of the children in Fresno County will be on Medi-Cal—50 percent—which means that children in Fresno County are going to be impoverished.

And the nationwide statistics are a quarter of our children. Shameful enough. Bad enough. But here, in this area, that half of the people in Fresno County will be impoverished and be on Medi-Cal and after you hear some of our other witnesses you will find that Medi-Cal simply isn't working.

Doctors aren't taking it. One example that Dr. Pfeffer—no, a pediatrician who is called to a Medi-Cal birth is getting paid $12, for a cesarean $60. It is a fraud. It is a program that is out there that is fraudulent and what is happening is the county facility has to pick this up.

And just that you understand, Mr. Espy, what we are up against in California, the Governor just slammed the whole health budget, medical health and health budget. So what is hanging over our heads is the sword that that would come down on top of the sword that Deukmajian took. We are talking about disaster.

Today we are talking about the crisis. When I set this hearing up I didn't know—it wasn't clear what I was going to learn and now I

am getting reinvigorated to go down to Mr. Condit's district where there are a lot of immigrants coming in, refugee populations, who are very resistant to child immunizations and 25 percent of the measle deaths in California were in Fresno because of cultural differences.

So we provided that scene to the Federal Government. What we didn't understand is that we have to provide people who speak the language to go out and persuade these families that they have to protect their children.

So we have a lot to do in the Central Valley here under the leadership of Gary Condit and Rick Lehman. I am really looking forward to working with them more now than I have done in the past because I feel I am getting information.

Let me call out the second panel. Michael Sullivan, Executive Director of the Merced Family Health Centers, Inc. Linda Perry, R.N. and M.S., Director of Community Health Services, Stanislaus County Department of Public Health and Ana C. Huesca, consumer.

We welcome you all. Please try to remain within the 5 or 6 minutes please. We will give you the 1-minute signal and we welcome you and we look forward to your testimony. Mr. Sullivan, why don't you begin.

STATEMENT OF MICHAEL O. SULLIVAN, EXECUTIVE DIRECTOR, MERCED FAMILY HEALTH CENTERS, INC., MODESTO, CA

Mr. SULLIVAN. Thanks for the privilege to present information to you and your Task Force related to health care access, Federal financing, and cost needs of underserved populations especially women, children, and minorities in the Central Valley.

My name is Mike Sullivan and for the past 25 years I have tried to improve the health care status of people in need both in the United States and in the developing third world.

I have three wishes that I know our Government can grant, however difficult the political realities:

(1) That we put in place soon a National Health Plan, its financing weighted toward prevention and primary care, and assuring equal access to all U.S. residents. I personally believe there is much waste, inefficiency, and institutional and personal greed in the current system, and an inordinate and lopsided expenditure of resources paying for hospital and specialist care that must be redirected.

Only when consensus is reached on a rational, accessible and prevention and primary care based health system, will we be in a position to control costs and limit negative outcomes such as high infant mortality which is a national disgrace.

(2) That rural America's (and the San Joaquin Valley's) special health care needs be fully integrated into the agenda of a National Health Plan. Specifically, rural Americans must achieve equal access to physician resources, especially primary care M.D.s.

There are too many physician underserved rural communities in America caused by lifestyle needs of young M.D.s, tremendous growth of female physicians, competition from foreign M.D.'s, and training methodologies in medical and residency programs creating dependency on high-tech equipment and facilities, and group practice association not available to rural communities. A National Physician Service or obligation will have to be incorporated into a National Health Plan.

(3) And finally, that until my first two wishes are granted, that there be a continued and increased grant financing to fill in the gaps of care needed by a growing underserved and uninsured population of high risk special people including the urban poor, the homeless, migrant farm workers, the rural poor, those on Medi-Cal, poor pregnant women, the children of our poor, and refugees from Southeast Asia.

I am currently the Executive Director of the Merced Family Health Centers, Inc., a Federal and State supported Migrant and Community Health Center. We operate six clinic sites as a nonprofit consumer-based corporation serving the poorest, most medically and dentally underserved populations in Merced and Stanislaus Counties. Our mission is to provide quality primary health care services in the communities we serve regardless of language, financial or cultural barriers.

Our agency has a work force of over 110 full-time employees serving more than 25,000 individuals which accounts for over 90,000 visits annually providing them with basic medical, dental, and nutrition care including the services of primary care physicians and dentists, nurse practitioners, nurse midwives, registered nutritionists, and certified physician assistants.

We support this clinical team with diagnostic laboratory and radiological services, pharmaceuticals, family planning and HIV education, childbirth classes, WIC, and total perinatal care, just to name a few.

Our patients are 70 percent Hispanic, 10 percent Asian, 15 percent white, and 5 percent black. They are mostly farm workers, but also include the homeless of Modesto, Southeast Asian refugees, the unemployed and the working poor.

In addition, we serve patients from six different language groups including Spanish, Hmong, Laotian, Vietnamese and Cambodian. All of our educational materials, consent forms, et cetera, are translated for our patients.

Nearly 55 percent of our patients are completely uninsured for health care services; for these patients, were it not for our agency, the only available sources of care would be the emergency room and the outpatient departments of the local county hospitals in Merced and Modesto.

Even for the 35 percent of our patients who are covered by Medicaid, options for receiving care elsewhere are extremely limited. Most private practice physicians refuse to accept Medicaid beneficiaries, or provide care only to a minuscule number of them.

Thus, while we are regularly overwhelmed with a number of uninsured patients far exceeding our capacity to care for them, you should also be aware that, in the Valley, as in so many communities across the Nation, we face an ever-increasing number of Medicaid clients who see us as the only truly available source of care left for them.

I am proud of the fact that, over the 18 years of our existence, Merced Family Health Centers, as is true of CHC's nationwide, has provided comprehensive, continuous, community-based primary health care services to thousands of valley residents who would otherwise have gone without care until they were seriously ill, or would have sought some form of episodic, noncontinuous care from some other source.

I know that, as a result of our presence and our work, our patients and the community as a whole, is healthier and more productive; and that as a result of our emphasis on prevention, early diagnosis and treatment, and health promotion, we have saved them, and society as well, both money and more importantly, lives.

But it is difficult, even for a Migrant Community Health Center like mine, to serve so many uninsured individuals and families despite the fact that we receive partial Federal support to do so. I have seen a dramatic increase in waiting time for new patients and appointments for nonacute care increased from a reasonable 1-month period to over 3 months.

Our experience has taught us much and we have tried to learn from it, but one important thing that it has taught me is that when you begin to talk about, or to consider options, for improved access to care for people who are not in the mainstream of health care today, it is not enough to focus on how the bills will be paid or by whom.

If you are truly interested in improving the health of these populations—whether they be uninsured, low-income, minority, non-English-speaking, homeless, substance abusing, HIV-infected, or whatever—then it is imperative that you focus on where they will go for care, not just on who will pay.

We need more ambulatory care providers, more clinics, staffed with qualified health professionals, to be access points for care, and to coordinate and manage the patients' care through other providers, both specialty and inpatient services, as well. I happen to think that the Community Health Centers can and should serve as the perfect model for such a system and with good reason:

They have 25 years of proven experience making health care accessible to underserved people and communities;

They are community-based, and therefore responsive to their communities' needs and circumstances;

They are closely monitored for adherence to strict management and financial systems;

They must meet rigid standards for quality assurance and the qualifications of their clinical staffs, and for the provision of important preventive and early diagnostic services; and,

They have provided and compiled an outstanding record for the quality of the care they provide. Their impact on the health status of their patients and the communities they serve is unquestionable. Their ability to contain costs, to operate with a fixed budget and limited resources, and their success in substantially reducing the frequency of admissions and the length of inpatient care are well proven.

Thank you for this opportunity to testify on behalf of the poor and uninsured patients of the Merced Family Health Centers, Inc.

[The prepared statement of Mr. Sullivan may be found at the end of the hearing.]

Mrs. BOXER. Thank you and thank you for the work you are doing. We will get back to you with questions but we will hear from the rest of the panel first. Ms. Perry.

STATEMENT OF LINDA PERRY, R.N., DIRECTOR, COMMUNITY HEALTH SERVICES, STANISLAUS COUNTY DEPARTMENT OF PUBLIC HEALTH

Ms. PERRY. Madam Chair and Members of the Task Force, I would like to begin by thanking you for coming to Stanislaus County and providing us with the opportunity to share our views on the problems we have here in the way of health care access and health care costs.

I have been asked to testify regarding these issues primarily from a child's health care perspective. I will address these issues

focusing on three priority population groups: Pregnant women, infants, and adolescents.

Pregnant Women

Any discussion of children's health care issues must include consideration of issues regarding prenatal care. This is because lack of adequate care during pregnancy is a primary factor contributing to some of the major problems affecting births. These include prematurity, low birth weight, birth defects and developmental delays and disabilities and, of course, infant mortality.

Early and comprehensive prenatal care is of major importance in the prevention of these conditions. Access to prenatal care for low-income women is a critical problem in this county.

Few physicians providing obstetrical services accept Medi-Cal, as has been discussed by all of the previous speakers.

The problem is compounded by the fact that most obstetrical services are centralized in the city of Modesto.

Because over 45 percent of the births in Stanislaus County occur to women living in less urban areas, a significant proportion of low income women have to find transportation to the city to receive prenatal services at all.

Due to this and other factors discussed earlier, this access problem has become a public health crisis in Stanislaus County.

A major solution to this crisis is the establishment of additional prenatal clinics, especially in the outlying areas. This decentralization of services would allow these low income women access to care in their own community.

The State of California has a mechanism for funding the provision of services through its Comprehensive Perinatal Services Program (CPSP). This program enables providers to give comprehensive perinatal services, including psychosocial, educational, nutritional and medical assessments. All of these services are reimbursable through Medi-Cal.

As a CPSP provider, the Department of Public Health has shown that with $100,000 seed money a clinic can be established and can become financially self-sufficient within 1 year. Due to current State and county restraints, however, seed money is not available to us.

Federal assistance, through the provision of seed money to establish clinics would greatly reduce the perinatal access problem that we have.

Children

Infants and children from low-income families experience problems similar to those of pregnant women regarding access to medical care. Because of the difficulty in finding primary care, providers who accept Medi-Cal, many low-income families do not have a physician and they seek their care through emergency rooms.

Community clinics need to be established offering a variety of needed services to low-income families. If this were accomplished, the problems with access and the inappropriate use of emergency rooms for basic health care could be minimized.

Resources currently exist for reimbursing the majority of services that would need to be offered through the community clinics; these include Medi-Cal revenues and funding from both State and Federal grants and programs. Again, the major problem here remains the lack of availability of seed money to establish these clinics.

Adolescents

Adolescents also experience a variety of access issues relating to medical care. The needs for this age group include general health care, as well as preventive health education regarding injuries, family planning, socially transmitted disease, AIDS and substance abuse; and mental health intervention relating to problems of emotional problems and issues of self-esteem.

Here again, the solution is the establishment of community clinics which are easily accessible and which offer programs designed specifically to meet their needs.

The group of adolescents with the highest level of need are the pregnant and parenting teens. Because of the multiple needs of this group, the best approach to service is the case management model. This is best exemplified by the Adolescent Family Life Program (AFLP).

Unfortunately, again due to fiscal restraints, relatively few adolescents can be serviced through this program.

One option for increasing the numbers of teens who could receive this type of care would be to make AFLP-type case management services reimbursable through Medi-Cal. This option is currently being explored by the California Department of Health Services and is going to require Federal support in order to be implemented. We hope that you will give us that kind of support.

Related Issues

Although access to health care is the major issue for all of these age groups, other issues are also of great concern.

Public outreach and education focused on the need for health care and its availability is essential. Education is also the key to the prevention of health problems before they occur. The availability of a 24-hour public transportation system for people in this county is necessary in order for all low-income people to be able to obtain the services they need, such as medical care.

As with other areas around the country, Stanislaus County is experiencing an increasingly severe problem with substance using pregnant women and their drug-exposed infants. There are not enough treatment programs or prevention programs in this county to assist these women in overcoming their chemical dependency so that they may provide appropriate parenting and child care.

To compound the problem, there are not enough resources through Public Health and other agencies to provide the in-home assessment and intervention needed for infants who were substance exposed prior to birth. Because of the magnitude of the problem, it is essential that the Federal Government assume a leadership role and work to assure that prevention and interven-

tion services are provided. We need your help. We can't do without it.

In summary, as with other areas of urban and agricultural mix, Stanislaus County experiences significant problems in access to health care. This greatly impacts the ability of pregnant women, infants, children and adolescents, to obtain appropriate health services.

Although we are striving to maximize the use of our available resources, gaps in service still exist here. It is essential that the partnership between the Federal Government and other agencies be expanded. Thank you.

[The prepared statement of Ms. Perry may be found at the end of the hearing.]

Mrs. BOXER. Thank you. We will get back to you with questions. Ms. Huesca.

STATEMENT OF ANA HUESCA, CONSUMER, MODESTO, CA

Ms. HUESCA. Madam Chair and Members of the Task Force. It is a great honor to be here today.

I would like to begin by saying a little bit about myself. I was 14 years old and in the ninth grade when I got married. It was very difficult for me to go to school. Because of being so young and married, people tended to look at me differently, especially other teenagers at school.

Then to make things even more difficult, I got pregnant before I turned 15 years old. This was really hard, since no one would hire me because I was a minor and I didn't have any skills.

So I had no alternative but to go to AFDC. This really hurt me at first because, even though I am poor, I have pride. Now I look back and I am so thankful I went there, because it was through them that I found out about the Teen Prenatal Clinic—TPC.

This clinic really helped me because it did not make me feel intimidated. The reason for that is that other girls my age were there. The TPC referred me to WIC and that was a really great help, because it really gave me part of the nutrition that I needed to have a healthy pregnancy.

I think that the WIC is an educational program because it teaches us how to eat healthy and how to take care of ourselves so that we could have a normal healthy baby. I think that if I would have gone to a regular doctor instead of the Teen Prenatal Clinic, I probably would not have attended the appointments so often.

It was the TPC who referred me to the Adolescent Family Life (AFLP) Program. I can't be thankful enough to this program because it helped me to have a higher self-esteem and to believe in myself. It also helped me to accomplish part of my goals. It was this program that introduced me to Independent Studies and through Independent Studies I was able to go to school and graduate.

If the AFLP would not have told me about Independent Studies, I think that all my dreams would have been shattered. I have three goals. One was to graduate. Thanks to Independent Studies and the AFLP program, I was able to do that. My second goal is to be a medical assistant and I will accomplish that in 4 more months. My

third goal is to be a doctor. I already registered to start in the spring semester at Modesto Junior College. I want to thank the Government for giving grants and student loans, because it is with these grants and loans that people like me could accomplish their goals.

There is one thing I admire about the AFLP program and that is their workers. For example, my worker, Rochelle Olson. She makes me feel like she really cares and she is not there just because it is her job. She proved that, because she went to my graduation and she didn't have to do that. That is why I believe that this program should be available to more teenagers so that they can be helped the same way I was helped.

Finally, at age 15, I had my baby girl. It was then that the AFLP referred me to the Nurturing Program. I really liked this program because I was able to talk about my problems and I was able to listen to other people's problems. That made me realize my problems were not so bad.

Another thing that I liked about the class was the way the staff took care of our kids. Sometimes the kids would be crying and screaming. I really admired the way the workers handled it. Because they were so patient and caring, it made me want to be the same way.

After my baby was born, I started to have many problems because only a few doctors would accept Medi-Cal. In other places, doctors charge for Medi-Cal. One thing that I have had a problem with is that hardly any dentists accept Medi-Cal.

The worst problem I have is that I don't drive and it is very difficult for me. If my baby would get sick, or if I would have any type of emergency after 6 o'clock, it would be hard for me to get transportation because that is the time the buses stop.

I would like to conclude by saying that I might just change my last goal and become an AFLP worker so that I could help other girls like I was helped.

I will end by saying thank you to this wonderful country for its beautiful program because, otherwise, teenagers like me would be forgotten. Thank you.

[The prepared statement of Ms. Huesca may be found at the end of the hearing.]

Mrs. BOXER. Thank you very much for your excellent testimony.

Somebody help me with AFLP.

Ms. PERRY. Adolescent Family Life Program. It is funded by the State of California. There are approximately 26 programs. The focus is to work with pregnant and parenting teens up to 3 years after delivery. It is a case management program where the health service workers and/or social workers go into the homes of teens to assess needs and provide in-home health services.

This is the program that I mentioned that needs Federal approval of Medi-Cal funding to expand. We service 86 girls a year in Stanislaus County. We have over 500 births a year. So at any one time there are about 1,500 young women who could benefit from services through this program.

We are hoping for Medi-Cal reimbursement or funding to help serve these other people.

Mrs. BOXER. Thank you very much for your testimony.

Congressman Espy, did you have some questions?

Mr. ESPY. Yes. First of all, Madam Chairman, transportation is a problem in many rural areas in California. I would like also to see more advertising of services on radio, TV, PSAs and transportation services.

Ms. PERRY. I think those things are being used and we are using Sierra Foundation moneys for many of them so some of the private foundations do have money for those things. It seems that this is one of the things that the Federal Government should look at.

Mr. ESPY. Is there any way that we can get more doctors to move into these rural areas?

Mr. SULLIVAN. If we have one problem in our community health center network, it is physician recruitment. We are right now dependent on private recruitment. We have to recruit the same way as every hospital in America, every private group practice, every Kaiser Health System out there. We are at a significant disadvantage.

The biggest thing we are doing, we are the last of the pipeline of the National Health Service. You may be familiar with it. That program was terminated by the prior president. When that happened, there were still physicians in it.

The first thing we are doing, we are trying to retain our current physicians. We don't want to lose them. Second, we are trying to recruit privately. We are doing the best we can, but it is an uphill battle.

It is tough for us to recruit to Dos Palos, CA. It is tough to recruit to the bayou of Mississippi, as you know. You know, we are significantly divided on new legislation, the National Health Services Corps, but again, that is a pipeline problem for us because that is a startup program that will take a couple of years to meet its fruition.

In the meantime we are also having to depend on nonphysician providers like nurse midwives, physician assistants, nurse practitioners, and that is a significant help, too.

Mrs. BOXER. Congressman, I was just thinking while you were talking that maybe there would be a way that we could come up with to forgive some of those old loans or trade them for new loans or whatever.

I have a question. I remember, back when I was on the board of supervisors, that the thing that we discussed then in the late 1970's and early 1980's was you can't have two-tier health care. Everyone has to have equal health care and that was when Medi-Cal was going to give everybody their chance.

Just have their card and go to the physician of their choice and have mainstream care. It isn't working and I think it is a shame and so I am very much impressed about how these community health centers function and how they can because it is a mix of people who come together because they care about serving, say, migrant people, get the translators there, the interpreters there, get the social workers—you can make a center.

And so I am not so sure we did the right thing when we said, mainstream health care because that is not possible among society as a whole any more. A lot of middle class people can't go to the

doctors of their choice. They now are joining HMOs because they can't afford any other type of private insurance.

So I think in talking about that in this crisis that we are in, we have got to get health care to these people. Babies are dying. There is no prenatal care. It isn't working. One has to go around and search for a doctor that takes Medicaid patients. The problem is a common one.

If she needs to speak to him in another language, what if he doesn't do that. And she doesn't have transportation to get to see him.

So I think a way out of this is maybe to say that the community health center is the way to go and give incentives to physicians to go there and saying, yes, we would love to have a situation where everybody had the exact same health care opportunity but we are failing.

And maybe if we admit that we are failing, we will get there. Yes, the health care system is working for some people, wonderful, but it isn't working for some others so I am coming away increasingly with that sense.

Mr. CONDIT. I appreciate being here very much today. I would just like to fill out what Mrs. Boxer was saying. Probably it is like everything else. You have to admit where you are before you can admit there is a problem. I think there are probably health practitioners all over the State who are saying, we need to be doing something different.

Yet we should make a distinction that the health care should be of the same quality for rural as for urban areas and I think that the philosophy is on the right track, that we need to have an entire health care system for this country, a national program that is comprehensive and includes those programs we mentioned plus the elderly, extended care, et cetera.

But I do have a couple of questions and I would like to ask Mr. Sullivan again because he was back in Washington with me a few months ago and spoke with me about the program.

And my understanding is that you are one of the last people in the program and I think this is such a good program, Congresswoman Boxer indicated that there are some things we could do to help these people take care of the loans.

It would be interesting to know what people like yourself specifically saw as something we needed and you said earlier that the renewal of the program is being proposed. If you like the program and want a reprieve today and want to submit it later in writing, that is fine, but I was curious about it.

Mr. SULLIVAN. Yes. Let me just with some brevity talk. I just returned from San Francisco and we had our executive clinical directors conference of community and migrant health centers in San Francisco at the Central Regional Office.

And I just want to share with everyone here that our physician medical director, John Alemane out of Merced, who started in the National Health Service Corps in 1981, served 2 years and since then has stayed on in our practice for the last 8 years as our medical director, received a national award from the Federal director of the National Health Service Corps.

So we are very proud and the point is, it can work. You can retain these physicians, but it is so key for us to get them here and I just want to comment that the revitalization of the National Health Service Corps is great and we are really pleased and the only sad part is that community groups like ourselves, when President Reagan was terminating that program under what we believed were some false data, that we missed the boat in not speaking up at that time.

But be that as it may, the Corps will be revitalized. We believe when you go back into session that the conferees will come together. Loan repayment is critical. Loan repayment is an immediate carrot for us to get there and we think that is significant.

That loan repayment still makes me nervous and I don't want to say it. We have been trying to recruit offering loan repayment because we have a couple of slots, for the last year and we get nowhere.

And I don't totally understand it except the marketplace, you need to understand, is a physician marketplace. It is not a community health center, Los Palos, CA, marketplace.

We offer what we think are competitive salaries and they simply can walk around the block and go into private practice and get their loan repaid, too.

Mr. CONDIT. Plus their own office.

Mr. SULLIVAN. Yes, so it is really a tough battle for us.

But I just finally want to say that we are working on it. If I had control of the program I would somehow take kind of immediate steps to, again, work on primary care and get out to those residency programs, get out to those medical students and really sell them on the value of a practice, a communal practice, where you are really helping people.

And that is the important things. We need doctors and we need, if you will, the right kind of doctors.

Mr. CONDIT. Can I have one more quick question for Ms. Perry?

Mrs. BOXER. Yes.

Mr. CONDIT. Could you just give us a quick idea of the increase in services, or requests for medical services in the last year or two for pregnant women using drugs and for AIDS patients?

Ms. PERRY. Oh, yes, I can get that to you.

Mr. CONDIT. Is it a substantial increase?

Ms. PERRY. We are seeing increases. I do have a statistic for you in terms of pregnant women using drugs. Our Senator McCorquodale just sent out a study that was done in 1988 showing that we had 70 referrals to child protective services on infants who had positive toxicology screens at birth. In the first 3 months of this year that number has been 60 so if we continue that the number for this year will be 240.

Mr. CONDIT. Thank you very much.

Mrs. BOXER. Thank you.

I would like to say that Ms. Perry, Mr. Sullivan, Ms. Huesca, all have worked very hard as a panel and I would like to thank this panel very very much. Again, we are learning things. You are telling it like it is. And we have to go back there and we have a lot of work to do because we have to convince a lot of people that this is a crisis and we can no longer turn our backs.

You are on the front lines and I thank you very very much.

I call on the last panel, Barbara Ross, Program Manager, Stanislaus County Adult Long Term Care Services, Dennis Hobby, Chairman, Dental Advisory Committee, Scenic General Hospital.

STATEMENT OF BARBARA ROSS, PROGRAM MANAGER STANISLAUS COUNTY DEPARTMENT OF SOCIAL SERVICES ADULT AND LONG TERM CARE SERVICES, MODESTO, CA

Ms. Ross. I am Barbara Ross. I want to thank you for inviting me to testify at your hearing this morning. I am here to speak for seniors this morning. I run a program which deals with seniors and disabled adults, and as I mentioned in my written testimony, I have also contacted many of the agencies who work with seniors within the community to get their input, to share their concerns with you as well.

I am going to summarize some of my testimony because you have heard it already. It is the same story again.

One of the major issues in Stanislaus County in health care for seniors is the lack of physicians, the lack of physicians who are accepting Medi-Cal patients, the lack of physicians who are dealing in geriatrics or who have that kind of specialty.

When I heard Ms. Finley mention that our teaching hospital is in jeopardy my heart sank because the residents coming through that program, training in that program, who stay in the community, are some of the best trained doctors that we have here in Stanislaus County and that program is a very big asset to our community.

Other specialties, seniors have trouble contacting other specialties, getting dental work done, getting podiatry, as I mentioned.

New physicians come into the community and accept Medi-Cal while they are trying to get a practice going. As soon as they have a successful practice they, again, stop taking Medi-Cal patients.

We have a problem with seniors who are ineligible for Medi-Cal due to either income or property limits. Many of these people have a share cost eligibility which does not help them except in a catastrophe. It doesn't help them on a day-to-day basis.

Just above SSI level there is a group of people who cannot afford supplemental policies, who cannot afford private payments and who simply can't get care. For example, I have here people who are below the benefit level who have some insignificant property which they are unable to liquidate.

It is not unusual for us to find a person who has moved to California, who is in a wheelchair, living in Modesto, but who has difficulty selling a small trailer in Arkansas left to them by a family member. They just simply can't get rid of that property. That renders them ineligible for Medi-Cal.

When basic choices need to be made for everyone, including seniors, housing and food come first, medical care is often neglected. It is not unusual for an elderly person to return home from a doctor's office and throw a prescription away. They are too embarrassed to tell the doctor they can't afford to have the prescription filled.

Another issue that becomes a problem for our seniors is reimbursement. There are many services vital to keeping people at

home which are not reimbursed by Medicare, others which are not reimbursed by Medi-Cal.

Specifically, Medicare does not pay for home health care which is considered custodial. It does not pay for durable medical equipment, for things like bathroom appliances. It does not pay for medication.

Medicare is currently paying for about 47 percent of an elderly person's medical bills. This makes supplemental policies a necessity. However, most supplemental policies pay for the portion left when Medicare pays. They do not pay for items or services which are denied by Medicare.

The complexity of the billing process presents a severe hardship to clients at a time of stress and illness when they are least able to cope.

It is not unusual for us to see seniors with a stack of bills and papers. They are ill, their families are ill. They are at a time of crisis and they have to deal with this.

Another thing, it is not unusual for vendors to bill clients directly for payment. The billing process is so complex, payments are extremely slow. A local attorney with CRLA shared with me that she has seniors coming in to see her every week that have Medicare supplemental insurance and who are being pursued by vendors for direct payment because they are not getting payments.

This can be caused by a mistake on a form, something that is not filled out right, documentation that is not done correctly, whatever it is.

Medicare does not pay for convalescent care beyond a minimum. This leads to a problem where people are spending their life savings, or a healthy portion of their life savings, for health care.

Accessibility is a problem here. You have heard about this for teenagers. It is also the case for seniors. Medical services and specialized services in particular are centrally located in Modesto. Seniors live everywhere in the county and we have many seniors in our outlying areas.

We have a tremendous problem in Stanislaus County getting medical services to the client and getting clients in to the medical services.

The Public Health Department has been operating a senior preventive health program which is excellent. They can deal with 700 seniors per year with their current funding. We have 57,000 seniors within the county.

Reaching outlying areas becomes more and more difficult as funding diminishes. At the same time transportation for seniors, especially frail seniors, is extremely limited. The area on our county's western border, Newman-Patterson area, is 20 to 25 miles away from Modesto. There are many elderly people that live there.

For an elderly person in that area to reach health services in Modesto, there is a bus once a week. For people who are unable to take the bus, there is no alternative.

For an elderly person with a walker, a bus stop two blocks away might as well be 200 miles away. It is not reachable.

Even within Modesto, for our frail elderly, the only method of transportation is a taxi of an ambi-cab. Our local service for elderly—our local transportation service for elderly—has extremely long

waits, up to 90 minutes at both ends of a ride and then the ride is like a bus trip. It goes all over town and many of our seniors just simply can't stand that process, can't tolerate that process.

Funding is a problem in Stanislaus County and in other small valley and mountain counties. We are at a disadvantage in applying for grants. Our county is considered urban for funding purposes because we have a city and, therefore, ineligible for money that is earmarked for rural counties, even though we have many of the same problems as a rural county.

Programs and funding are clustered in the large metropolitan areas and seldom reach the Valley. We do not have large nonprofit corporations and agencies which specialize in grant writing.

Now and then a decision is made by a funding source to earmark a valley or mountain site for a program which leads to many needy areas competing for one-site selection.

When we are able to write grants to compete for programs, it is a grassroots effort of concerned people who share their time, energy and efforts to bring a needed service to the county.

When we are awarded a grant, it is often a drop in the bucket as far as filling a need is concerned. For example, we were finally able to receive a grant for a Valley Regional Research Center for brain impaired adults through the State Department of Mental Health.

Our Regional Research Center covers nine counties, approximately 7,200 square miles.

In Modesto we have one staff person to cover a four-county area. The amount—when resources were divided over this gigantic area—the amount for Stanislaus was so minimal as to be nonexistent. The waiting list for this program grows daily.

We have one adult day care center serving approximately 30 people, one Alzheimer's day care center serving 30 people. There are no other day care centers. Funded respite in the area is limited to a handful of slots.

It is very important, when you are looking at health care for seniors, that you look at the entire picture for seniors. It is not going to be helpful to create a situation where a senior can get into a doctor's office if, on the other side, you are taking away nutrition programs so that when they get back home they can't have lunch.

Services and needs for seniors are interrelated. I have worked in this field now for about 5 years but for 20 years total and it seems as if we are always coping with having the edges nibbled away at our funding.

One of the Medi-Cal issues that comes up, I think, more and more often is that to protect the Government from fraud, from people abusing the system, they create more redtape and more forms and more levels. That is part of the reason that physicians are not taking Medi-Cal any more because it is just too difficult for them.

The billing process is too difficult. They are not getting paid. The documentation needs keep getting higher and higher.

In summary, primary health care needs for the elderly: No. 1, are physicians; No. 2, are preventive health programs such as the one that we have here that Public Health is doing, outreach programs, education in the areas where seniors live, or transportation

to get seniors into the areas where the services are located; expansion of in-home service options; health insurance coverage which is responsive to the needs of the people; simplification of the approval and billing process within that insurance program and programs for special needs such as Alzheimer's, stroke, programs such as day care, respite, counseling and case management. Thank you.

[The prepared statement of Ms. Ross may be found at the end of the hearing.]

Ms. BOXER. Thank you very much. Dr. Hobby.

STATEMENT OF DENNIS HOBBY, D.D.S.

Dr. HOBBY. Madam Chairman, Mr. Condit, Mr. Espy, my name is Dennis Hobby and I am a practicing dentist here in Modesto. I am a member of the American Dental Association, the California Dental Association and the Stanislaus Dental Society.

I am also the chairman of the Dental Advisory Committee at Scenic General Hospital, which is our county facility. You have heard from them earlier. In that capacity, I have volunteered time over the past 3½ years in what I am happy to say has been a successful attempt to establish a county dental clinic.

When I began my practice 5 years ago, I anticipated that there would be a place in my practice for all types of patients and reimbursement schemes. However, for reasons I will go into momentarily, I was unable to accept Denti-Cal patients.

Therefore, I saw, and continue to see, some patients on a charity basis, so my remarks today are from the perspective of a practitioner who, while not dealing with the Denti-Cal system per se, nonetheless observes the continuing problem of how poor patients, including those with Denti-Cal coverage, obtain care.

Five years ago, I perceived that the Denti-Cal program was in crisis. There were dentists in the Modesto area who accepted Denti-Cal patients and, while they may have complained about marginal reimbursement, seemed to be content in doing so.

As a new practitioner, however, with all the startup costs associated with equipment purchase, repayment of student loans, et cetera, and overhead of approximately 80 percent, I could not see a place in my practice for patients for whom reimbursement would mean a loss for every service rendered and I therefore never accepted Denti-Cal patients.

Over the intervening 5 years, the situation has worsened and my perception of a crisis in the Denti-Cal program has grown more profound. Very few dentists, and almost no pediatric dentists, will now accept new Denti-Cal patients.

A report recently published by the California Policy Seminar stated that statewide, fewer than one in six general practice dentists will accept new Medi-Cal patients, and that many rural counties have no dentist who will accept new patients. In Stanislaus County, we currently have only six dentists willing to accept new patients, with an eligible population of close to 60,000.

In a State where only 17 percent of the population drinks optimally fluoridated water, early access to dental treatment, particularly preventive treatment, is especially important. The dental pro-

fession takes pride in its longstanding policy of stressing home care, regular checkups and cleanings, and fluoride treatments.

The existing Denti-Cal program ignores those maxims in its criteria for care and instead seems to adopt an attitude that discourages treatment by ethical practitioners while promoting the wholesale rendering of services by providers willing to look for the loopholes in the system.

Specific problems with Denti-Cal are:

(1) Fees cover only two-thirds of the dentist's overhead costs, meaning a financial loss for every service rendered. (Average dental overhead is in the 65 to 80 percent range.)

(2) An inadequate scope of benefits which does not allow ethical practitioners to provide comprehensive, cost-effective care with an emphasis on prevention of disease.

(3) An administratively complex claims processing system which denies 1 claim in every 13. This system requires excessive X-rays, burdensome written documentation for routine services, and additional postage on oversized envelopes.

The Policy Seminar's report cites these problems as reasons why Denti-Cal fails to meet Federal Medicaid requirements for adequate provider compensation and patient access to care.

I realize your mission at this hearing is not entirely to focus on problems of medicaid recipients, but before moving on, I feel compelled to publicly state my belief that the current Denti-Cal program cannot be fixed by continuing to tinker with it as has happened in the past several years.

Tinkering has brought about a completely failed system that should be scrapped. In its place, I would hope to see a reasonable, cost-effective program that has the patient's welfare—not the Government's pocketbook—in mind. And I believe that that can be accomplished within the confines of a limited budget.

In fact, that is our goal at the Scenic General Clinic: A cooperative effort between the profession and Government. This will complement what our dental society has done through its Mid-Valley Dental Foundation, which annually donates $60,000 worth of care to needy children.

I have attached to this written testimony the executive summary of the Policy Seminar's report, for your information.

Now, let me touch briefly on the dental aspects of health care as a whole. The economics of dentistry are different from those of medical and hospital services, a distinction few policymakers recognize.

One significant difference is in cost: dental care has not risen in cost at the rate medical care has; in fact, in the past 15 years, it has generally stayed below the Consumer Price Index.

Another equally important distinction is the nature of dental disease: It is preventable and, unlike some medical conditions, it will not heal itself without therapeutic intervention, which makes early diagnosis and treatment imperative and cost-effective.

The need for dental care is universal and on-going, not episodic, and that need is highly predictable. Patient cooperation and self-care are critical to successful dental care. These factors are essential when considering how to pay for universal dental care.

The delivery system in California is a good one, resulting in the highest standard of dental care in the world. Unfortunately, that

standard of care is not uniformly accessible to the poor and those in long-term care facilities.

I am proud to represent a group of caring professionals who willingly volunteer their time in schools and clinics, as I do, and who stand ready at all times to meet the challenge of changing our system.

The burden of unmet need, however, is too heavy to be met entirely by the profession without assistance. We believe dental and medical care for the poor is a societal, community problem best addressed by cooperative efforts of the private sector and Government. Thank you.

[The prepared statement of Dr. Hobby may be found at the end of the hearing.]

Mrs. BOXER. Thank you very much, Dr. Hobby. I always thought that dental care has not been looked at as health care, and it is. It is health care. As a matter of fact, a lot of these terrible diseases sometimes show up first in the mouth, like AIDS in some cases.

I want to ask you a couple of questions about this clinic. When people come into the clinic, do you take their Medi-Cal payment or Denti-Cal?

Dr. HOBBY. Well, first of all, let me tell you, the clinic is not open yet. We have—there has been a dentist hired. Let me tell you what our vision for the clinic is and then you can keep an eye on us and maybe it can be a model for others.

It is a cooperative effort. Beth Finley from the county hospital is here. She has been very helpful. What we are trying to do is, we have now got a dentist who will serve 50 percent of the time in the clinic, 50 percent as an administrator on staff.

We are going to start with some of the minor programs that we are responsible for care for in this county, the MIA program, for example.

Mrs. BOXER. What does that stand for?

Dr. HOBBY. Medically Indigent Adult. They fall through the cracks of Medi-Cal and they are the next class.

Mrs. BOXER. Uninsured.

Dr. HOBBY. Right. We hope to expand the care from there, we hope in the future, to add a couple of residents, just graduated dental students, who would be willing, at a reduced rate, to work in the clinic for the experience that they would get.

And if we could turn those people every couple of years, that would add help.

And then, in addition to this, we are hoping that the dentists in the community will come in and either volunteer their time or work at a reduced scale to take up the slack.

It is one thing to ask a dentist to volunteer a few hours of their time to come in and see patients. It is another thing to have them take time out of their busy practice to see a patient who, they are only going to get reimbursed two-thirds of what it costs them to do the procedure.

And we are hoping, by having a facility—and some other areas talked about the seed money for facilities. Once they are there, we are hoping that with the limit constraints—and I realize that there are budget constraints, but what we are trying to do is use the money more frugally and if we are not paying someone else's—if

you don't have to make a profit at it you can obviously run a much more efficient show.

Mrs. BOXER. So what you are saying is, if you got the seed—your theory is, if we look at this as a model and it works, if you were able to get seed money to, say county hospital, use that as a start, to open up dental clinics, and then as part of the expenses to pay a limited number of people to do the basic work and then try to get dentists who are walking away from Medi-Cal because they are not only losing money, they have to fill out all the forms and all the bureaucracy and the aggravation that they don't want to put up with to volunteer their time rather than take a patient and lose money.

Dr. HOBBY. That is correct.

Ms. BOXER. You are saying the dentists would look at that in a better way. But it gets back to the whole point I was making before, the idea of community health centers where people can come and get their needs taken care of. When will this open?

Dr. HOBBY. September 15 was the last date that I have.

Mrs. BOXER. So you are waiting until the middle of September to make sure that the office is arranged.

Dr. HOBBY. Yes.

Mrs. BOXER. And will that plan accept DentiCal and Medi-Cal as payment? I assume you would take it.

Dr. HOBBY. We will.

Ms. FINLEY. We will treat indigents first because they don't have any access to dental care.

Dr. HOBBY. Right.

Mrs. BOXER. You know, isn't it amazing what you just said, we will treat the indigent first. What about Medi-Cal first? They are indigent, but they are better off than the indigent non-Medi-Cal person.

I mean, really what is happening in society is this group of people in the middle who are the working poor who have no insurance, and it is kind of a desperate situation. This is a completely different situation than we have ever had before and very alarming.

The only plus of it is, I would hope that the Congress and the President might wake up a little quicker when we find out that it is people that are working and trying to make it that are having such a difficult time.

Congratulations to you on what you are doing.

Ms. Ross, I would just say that your comments are right on target. You are describing a situation where, because of a lack of transportation—you are tying it all together because of lack of transportation the access is so limited and it doesn't sound like it is too pleasant for seniors who don't drive and don't have the financial capability of it.

Mr. Condit, any questions?

Mr. CONDIT. Madam Chairman, I do, and I want to follow up on your point which I think is a very good one about the working poor falling through the cracks and I think that we can stay here all day and talk about why that happened and refer also to some policies of an ex-president. However, you know, we must move on.

Another problem also I think that is equally ludicrous, you know, if you have a Medicare patient able to get services but one that doesn't qualify for Medi-Cal, it is also a problem of Government wanting you to become truly indigent before you can qualify which imposes on this eligibility problem, Ms. Ross, that you brought up.

This situation that you brought up of the wheelchair bound person in this county who has some kind of a trailer in Arkansas that he or she can't get rid of and because they have this commodity, they can't qualify? I mean, that makes no sense to me, Madam Chairman.

It is like a situation that we considered in the Agriculture Committee when we were marking up the food and nutrition act that we just passed and we had a particular hearing about eligibility problems.

And if my memory serves me correctly, we have a problem in West Virginia, where an indigent person, when they considered their income eligibility, this person qualified for donated clothing by some charitable group and the food and nutrition group of the USDA considered this as income, thereby disqualifying this person for food stamps.

Another situation of a blind food stamp recipient having received dog food for the guide dog, seeing-eye dog, and because they didn't have to pay for it that counted as income which also put her over the threshold for eligibility. It doesn't make sense.

Ms. Ross. And then there is something called spend down. That is what they call it, when you have to spend your savings, when you have to spend the money that you worked all your life to save in order to qualify for the program.

Mr. Condit. So that is my question. How would you revise the eligibility formula? Do you see anything that we could do right now to weed out what I think is a ludicrous situation, you know, a wheelchair person here having to somehow name a mobile home in Arkansas?

Ms. Ross. You know, the Medi-Cal share of cost system works for catastrophic coverage. Are you familiar with that system? Basically, you know, if you are within the property eligibility criteria, if you happen to be hospitalized, if you are employed they take your income and for that hospitalization you pay a portion and Medi-Cal will pick up the rest and that works for catastrophic coverage.

On a regular basis of preventive health care it doesn't really work. Possibly something like a fee for service basis for people, the idea of community clinics, the idea of community clinics going out. You know, I don't know if that is even possible but I think it would solve some of the problems.

Another thing that would solve the problems—many of the services that you will find in the Bay Area and in Los Angeles are on a sliding scale fee for service and there are programs that are funded as well so that they have a funding structure and then a fee for service based upon what you are able to pay.

As I said, what the problem is, many of those programs don't get into the valley, don't get into the mountain counties. They are clustered in the Bay Area. If we had more opportunity for those kinds of programs here, that would be helpful.

Mr. CONDIT. Thank you, and to Dr. Hobby, I was also interested in the extent to which the Government participates in the program that you mentioned. The Mid-Valley Dental Foundation?

Dr. HOBBY. The Government does not participate in that at all. That is, the dentists themselves commit that money and run that program in conjunction with school nurses. The school nurses identify the children that don't qualify for the dental care, don't qualify for the other programs.

They then refer them to a staff person that we have who then provides dentists in the community and we donate dollars and also hours of care.

Mr. CONDIT. I am sorry, I got the wrong program. It is the Scenic General clinic?

Dr. HOBBY. Yes, that one, Scenic has used some one-time-only moneys to provide the equipment and locate the space, the rent and pay the Director's salary for at least 2 years. That is our seed money that we talk about.

Mr. CONDIT. From the Government.

Dr. HOBBY. Right. The private sector—what we are hoping to do is, we have done the leg work and provided the guidance in doing what they are doing with that money and then I help them identify and interview dentists and then we will help them as an advisory committee to run that program and continue to keep it staffed and then volunteer time in the clinic itself so it is a kind of a—we are hoping that with the moneys available, because it is limited, and once we have the clinic up and running we can use the moneys more effectively than a fee for service basis where it doesn't work because the fee for service is not enough to get the service.

Mr. CONDIT. Have you, and how have you involved the megabody—in this case it would be the American Dental Association—because if this thousand points of light scenario, if it is going to work you have got to have everyone involved and, you know, if Government has a role and private dentists, in this case, have a role, I think a group that we have left out of this equation has been the professional groups, you know, the national groups and multinational professional groups, the American Dental Association and the American Bar Association.

They have incredibly wealthy coffers that I think might have been brought into the problem. Have you recommended to you—have you submitted——

Dr. HOBBY. Well, we are a tripartite system, which means I belong to all three groups, the local group, the State group, and the national group.

Mr. CONDIT. Do they belong to you, though?

Dr. HOBBY. Yes, we are them. I mean, you know, I feel that way about our organization, anyway.

Mr. CONDIT. It percolates up, though, doesn't it. It doesn't percolate down.

Dr. HOBBY. As far as dollars?

Mr. CONDIT. Yes.

Dr. HOBBY. I don't know—we as a local community do what we decide to do. You know, we deal with them but they are not—I don't think they are an economic entity as far as care giving is concerned. They are an economic entity——

Mr. CONDIT. That is my point.

Dr. HOBBY. They are an economic entity in the fact that I am a member of that organization and I take my time to volunteer and do these things as part of that organization but are you suggesting that we pay dues to the ABA so that they can fund dental programs nationwide rather than on a local level, doing what we are doing? I feel that we are more effective on a local level.

Mr. CONDIT. I am saying that your very worthy effort here could be duplicated through the action of the national board of directors of the American Dental Association if they were informed about your effort here in this county and State.

Are you saying to me that you would not—I don't want to make it personal. Just let me say, if a prototype project, if a demonstration type project such as this one were to be presented to the national board of directors of the American Dental Association, do you think this proposal would fall on deaf ears in terms of funding or supplemental funding elsewhere?

Dr. HOBBY. I have no idea of their funding—I have no idea what their funding requirements are or what their programs are in that light. If it worked, I would certainly be willing to present it but I have a feeling it would be—it is just my own personal feeling, maybe I am wrong—that it would be more of them being in the informational mode to say, this is what was done in California, let us help you set one up here.

I am not sure that the dollars are available. I don't want them to raise my dues. I would rather do what I do here locally and just give them the model, I guess is what I am saying.

Mr. CONDIT. Thank you. Well, if 80 percent of operating a dental office is overhead expense, what I am thinking is—I am not familiar with AMA or ADA but I am with ABA and I know that a lot of your dues go to overhead costs of operating that national organization.

And some of that money could be better spent for community legal services, and that is my point with the American Dental Association.

Mrs. BOXER. Thank you very much. Mr. Condit, would you like to ask a question?

Mr. CONDIT. Yes, I just have a couple of comments and maybe it will turn into a question and it is about the spend down policy. I have seen the spend down policy for a number of years, as I know you have as well and it has concerned me greatly.

I have visited a number of senior citizens who have a little house that they worked 30 years for, have $10,000 or $12,000 in the bank. They were sick. They probably would have been better off if they had stayed home and had in-home service. Got sicker worrying about the spend-down policy, that they have $10,000 or $12,000 that they were saving for a rainy day.

When that was gone they had to get rid of the house that they might have wanted to leave to the kids. I think that is outrageous.

You know, I can understand—we are not talking about people with $250,000 in the bank and we are not talking about wealthy people. We are talking about what has been referred to as working class people who worked real hard to get a home. They deserve to

leave it to the kids and I think they are entitled to health care without giving their home away.

And I think if we were going to change something in terms of the qualifications for these programs, they ought to at least be able to keep their homes. Maybe they ought to spend out of their savings account. Maybe that is the rainy night. I don't know. But at least they ought to be able to keep their home.

I think that whatever we do at a national level in changing this, and maybe you can respond to this, I think people are more healthy when they are able to stay at home. I remember my grandparents, if they could be home, they were healthier, happier, and it seems to me that we ought to do everything that we can to keep them in their homes and in the long term it will probably cost us less money.

That is my comment. I don't know if you have a response or not.

Ms. Ross. I think that every step on the continuum of care is important. You know, your hospitals are important, skilled nursing facilities are important, residential care, in-home care, and they all have to be addressed.

And one of the things, it seems to me, that health care never really looks at is preventive care that you are talking about, someone who can stay home and receive services in the home. Surely that would be a cost savings in the long run, over acute care hospital care, more expensive medical care.

Mr. Condit. And I would like to just close by commending Dr. Hobby and Beth Finley for what I think is coming up with a good idea with the Dental Association and county hospital coming together to try to provide some dental care for the people in this county.

We don't know if it is going to work, but if it does work, I think you will take it back to your national association as a model program and I know that you guys have been working on it a long time because I met with you and I wish you well and commend you for at least trying to come up with some way of dealing with this problem. That is all I have to say.

Mrs. Boxer. Thank you so much, Congressman, for welcoming us to your wonderful Congressional district and helping us put this together and to your staff I say thank you.

And to Mr. Espy, from coming all the way from Mississippi to come and visit this which is what we have decided is your second home.

Mr. Condit. That is correct.

Mrs. Boxer. Just a little bit of technical business. I ask that the testimony that was received in Fresno yesterday be incorporated into this hearing record.

Hearing no objection, that will be done.

This hearing stands adjourned. Thank you all.

[Additional material submitted for the record follows:]

Prepared Statement of Anna Phillips

I have been requested to address the issue of Health Care Crisis—Teenage Pregnancy. As Director of Health Services for Fresno Unified School District which serves approximately 68,000 students, I am very aware of the significant health

problems associated with teenage pregnancy. In our school district, girls who are known or suspected to be pregnant are referred to the school nurses.

During the 1986–87 school year the nurses started maintaining and reporting data regarding pregnancies. That year 454 pregnancies were reported; one at 12 years of age, five at 13 years, 23 at 14 years, 91 at 15 years, etc. Thirty-one students had a second pregnancy and two had a third pregnancy. The greatest number of pregnant students were Hispanic.

In 1987–88, 552 pregnancies were reported; 67 second pregnancies and 11 third pregnancies.

In 1988–89, 554 pregnancies were reported; 73 second pregnancies and 13 third pregnancies.

The 1989–90 statistics are not complete but as a subtotal we have 562 pregnancies; 72 second pregnancies and 16 third pregnancies.

When we look at numbers of significant health problems, i.e., asthma, diabetes, seizure disorders, orthopedic problems, etc., and reduce our population by half (excluding males), we see teenage pregnancy second only to asthma and allergies in numbers of students affected. It is a major health risk for our students.

Setting numbers aside and giving consideration to the impact of pregnancy on the health of the teenager and the infant, we see how devastating this problem can be. The following are examples of the health problems experienced:

Adolescents:

— severe anemias (one student required transfusion after her second pregnancy and then got pregnant again)

— urinary tract infections, pylonephritis

— ectopic pregnancies, surgeries

— toxemia, preeclampsia

— numerous Caesarian deliveries (one student had a third C section)

— complications of existing health conditions due to pregnancy, i.e., seizure disorder, arthritis, scoliosis, diabetes, congenital heart disease, etc.

— post partum infections and post partum hemorrhage

— a student with severe toxemia suffered a cardiac arrest during delivery; another delivered prematurely, had a stroke and has limited use of one leg

— several students have been hospitalized with severe nausea, vomiting, dehydration and weight loss

Infants:

— many babies have been born prematurely (15–20 over past 3 years) weighing as little as 1 lb. 12 oz.

— several still births, one baby born with Trisomy (genetic defect causing severe deformity and mental retardation)

— two babies born with gastroischesis

— one baby with hydrocephalus who is now a patient at Porterville State Hospital

There are a brief, minimal listing of the problems experienced by our students and does not include the depressions, pregnancy associated with rape, the child abuse referrals for either or both the adolescent and the infant, and the appalling dropout rate of the girls.

Access to care does not seem to be a major problem. Although a few of the girls have delivered with no prenatal care, the school nurses see that almost all of them receive medical care, primarily through the use of a Medi-Cal card. What is greatly needed is more efforts toward prevention and better case management of students who are pregnant to ensure regular prenatal care and to assist students with the psychosocial and educational aspects of their situations.

I am pleased to have an opportunity to share this information and hope that Federal funding may be increased to provide additional services for pregnant and parenting adolescents.

PREPARED STATEMENT OF JACK K. WALLER

For the record, I am Jack K. Waller, Chief Executive Officer of Selma District Hospital, a 65 bed acute care hospital located in Fresno County. My statement will cover the following three points:

1) Federal Funding for Health Care

2) Cost of Health Care

3) Access to Rural Health Care

On the first point, as a practicing hospital administrator, I am totally dismayed at the Medicare funding cuts over the past five years. The DRG payment system under PPS (prospective payment system) is a completely inequitable situation for hospitals under 100 beds. The bureaucratic paperwork is unreasonable and the utilization review process costs hospitals even more money. Also, the risk to small hospitals is greater since the urban-rural differential is significant on the order of 14-17%. Small hospitals are not fairly treated under the Medicare PPS system. Specifically, the proposals to add-on capital equipment to the DRG rate will be a disaster for small hospitals. Most rural hospitals were built in the 1950's with Hill-Burton funding. These facilities are now due to be replaced and the add-on to DRG's will not be adequate.

On the second point of the cost of health care, I believe that ultimately we will see 15% of GNP. This is an increase from the current 11% rate. Quality health care is manpower and technology based so, therefore, as new equipment and new technicians are introduced . . . . the cost goes up. However, patients benefit from improved quality of life with total hip replacement surgery, cataract eye surgery, and MRI imaging of arthritic joints. Each of the items I just mentioned are offered in my 65 bed acute care facility. Senior citizens are able to use my hospital since it's close to their homes. No public transportation exists in the area and some seniors don't drive automobiles at their advanced age of 70's and 80's. We can't turn away from the needs of older Americans.

On the last point of access to rural health care, I am convinced that rural services are absolutely mandatory! Our federal health care system has been supported by rural workers' contributions to Social Security. Likewise, these payors should be able to receive benefits in their small towns and local area. I guess my point would be that this country was built on farms, small shopkeepers, and small business enterprise. We can't abandon our senior citizens at their time of health care need. To expand on this point, let's keep in mind that rural America has been hard hit by service reductions from the state and to add Federal cuts would be overwhelming.

In summary, I suggest major changes in Medicare are needed and this task force can be instrumental in that effort. Congresswoman Boxer, I appreciate this opportunity to give testimony and would entertain any questions.

Thanks.

Enclosures.

California Rural Hospitals

ISSUES '90

Prepared for the Washington, D.C. Congressional Visit, June 1990, by the:

- California Association of Hospitals and Health Systems Rural Hospital Center
- Hospital Council of Northern and Central California
- Hospital Council of San Diego and Imperial Counties
- Hospital Council of Southern California

Introduction

California's small and rural hospitals play a special role in the state's health care system. Located in sparsely populated, often isolated communities, these facilities serve as the center of the health care delivery system for residents and travelers. They also assist in maintaining the economy of rural areas by serving as major employers.

Rural acute care hospitals also provide the medical back-up necessary for the development and operation of long-term care services for the aging population of rural California. Without this "hub" of health care, many communities would not have the basic health services necessary to: 1) sustain life in an emergency, 2) treat day-to-day illness, and 3) provide care to the acute and chronically ill.

There are currently 83 rural hospitals in California as defined by peer groupings under Section 1188.855 of the California Health and Safety Code.

Thirty-six California rural hospitals are district hospitals supported by a local tax base. An additional 20 facilities are nonprofit; 10 are owned by local government; nine are church-affiliated and eight are investor-owned and operated.

Facts About California Rural Hospitals

Size, Services and Utilization

(See Figure 1 for utilization data.)

- 83 rural hospitals (as defined by the state)
- 49 rural hospitals (as defined by the Medicare program)
- 27 sole-community provider rural hospitals
- 1.3 million population in federal rural counties
- California rural hospitals range in size from four to 98 licensed acute care beds
- 25 rural hospitals have DP/SNF programs
- 14 rural hospitals have swing bed programs

Figure 1 • California Rural Hospital Utilization Data

	1984	1987	1988	1989 (est.)
Total Discharges	132,614	117,387	116,952	119,300
Percent Medicare Discharges	•	38.7	40.0	40.7
Percent Medi-Cal Discharges	•	15.8	15.6	16.1
Total Patient Days	•	734,400	753,452	774,800
Percent Medicare Days	•	36.9	35.7	37.9
Percent Medi-Cal Days	•	32.1	34.6	32.3
Length of Stay	5.5	6.3	6.4	6.5
Outpatient Visits	1,201,000	1,550,000	1,700,857	1,826,000

• Data not available

Source: OSHPD Annual Disclosure Data (1984) and Quarterly Financial and Utilization Data (1987-1989.)
Data base includes 83 rural hospitals as defined by Health and Safety Code 1188.855.

Magnitude and Role of California Rural Hospitals

- During 1989 discharged over 119,000 patients. This is more than the total discharges from all hospitals in each of eight other states.
- Only 19 of California's 83 rural hospitals are located in communities with more than 10,000 residents. Rural hospitals make services available and accessible to small populations.
- California's rural Medicare counties have a total population of 1,302,700 residents projected for 1990, larger than the total population predicted for 1990 in each of 12 other states in our nation.
- Due to county roads, fog, snow, mountains and flooding, 85 percent of rural hospitals in California reported that some time during the year, the trip to the next closest hospital is over two hours.
- Although California is one of the nation's largest rural states, its rural health care problems are sometimes overlooked because California is one of the largest urban states. Eighty-five percent of California hospitals are urban, 15 percent are rural.
- Due to California having large counties, many California hospitals that are located in urban Medicare counties actually serve rural

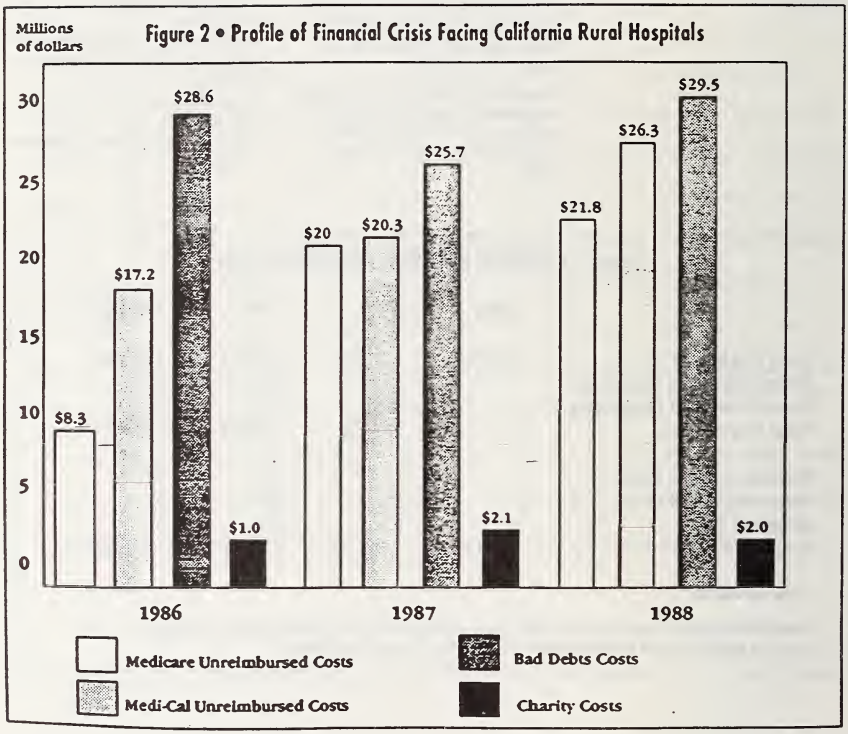
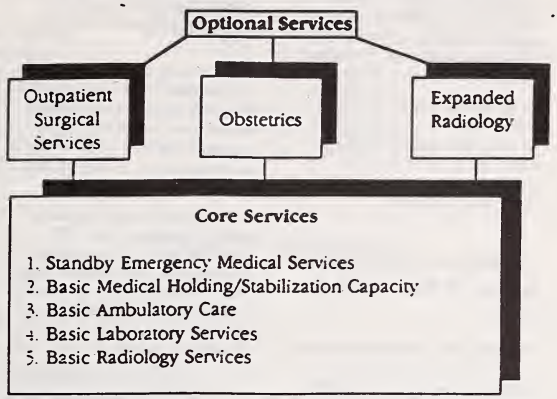


Figure 3 • Proposed Alternative Rural Model Hospital



populations and these hospitals and their patients would benefit from programs that at present are only available to rural designated hospitals.

Financial Issues

• Since 1983, 13 California rural hospitals have closed, second only to Texas.

• During 1989, 70 percent (58 out of 83) of California rural hospitals experienced a negative operating margin.

• Outpatient visits have increased over 50 percent while inpatient discharges decreased by 20 percent during the past five years preventing the use of economies of scale, making it difficult to maintain an inpatient facility as well as retain medical staff.

• While inpatient discharges are decreasing, the average length of stay and the percentage of inpatient care paid for by the government have been increasing *(See Figures 1 and 2)* creating a financial burden for rural hospitals.

• Two rural hospitals in California which had negative operating margins merged in 1989 and are being investigated by the Federal Trade Commission (FTC). Rural hospitals should be exempt from FTC regulations that may arise from mergers, acquisitions, consolidations or other cooperative efforts with other health care facilities.

Human Resource Issues

• Over 95 percent of California's rural hospitals have experienced difficulty in recruiting one or more of the 15 most common categories of health personnel.

• Approximately 80 percent are actively recruiting physicians during May 1990.

• Seventy percent are having difficulty recruiting nurses.

• Thirty-five percent are having difficulty recruiting radiology technicians and laboratory technicians.

• Over 20 percent are having difficulty recruiting physical therapists and respiratory therapists.

Physical Plant Issues

- Due to their financial state, rural hospitals cannot fund depreciation. As a result, many have physical plants that require capital. Twenty hospitals have physical plants that average over 10 years of age.

- Due to strict seismic, licensing and fire codes, it is estimated by the state that regulatory requirements add up to 60 percent of hospital construction and renovation costs in California.

The California Rural Hospitals' Response To Rural Health Care Issues

The focal point for addressing rural hospital issues is through the California Association of Hospitals and Health Systems (CAHHS) Rural Hospital Center (RHC) which serves in an advisory capacity to the CAHHS Board of Trustees. The Rural Hospital Center Advisory Board (RHCAB) works in conjunction with the Hospital Councils (Hospital Council of Northern and Central California, the Hospital Council of San Diego and Imperial Counties and the Hospital Council of Southern California) and coordinates its activities with constituency groups that serve rural hospitals.

Some of the major activities of the RHCAB are:

- Conducting an annual Rural Hospital Symposium to keep rural hospital administrators up-to-date on rural health care issues.

- Providing technical assistance to the Office of Statewide Health Planning and Development (OSHPD) in the development of an alternative rural model hospital (ARM). *(See Figure 3)* The model allows rural hospitals to meet state licensure and certification requirements and Medicare conditions of participation requirements while offering a limited scope of services similar to that proposed under the proposed federal Rural Primary Care Hospital. It is estimated that approximately 20 hospitals in California can benefit from the ARM.

- Sponsoring and co-sponsoring state legislation to relieve rural hospitals of unnecessary regulatory burdens and to assure that there is a coordinated and responsive effort at the state level to address rural hospital problems.

- Providing technical assistance to rural hospitals through 1990 programs such as the publication of a department-specific rural hospital financial analysis management tool and a statewide rural hospital public relations program entitled *Hometown Healthy*.

- In conjunction with the hospital councils, keep federal and state legislators and legislative staff up-to-date on rural hospital issues and concerns.

Summary: The California Rural Hospital Crisis

- Due to its large rural population and geographic area, California rural hospitals are heavily affected by the problems which affect our nation's rural health care delivery system.

- Medicare and Medi-Cal unreimbursed costs, bad debts and charity costs increased over 50 percent in California rural hospitals between 1986 and 1989, totaling over $83 million in 1989. As a result, California rural hospitals as a whole have had negative operating margins for four straight years.

- Due to travel time and weather, accessibility to rural hospitals is already a problem. Additional rural hospital closures which are on the brink, will affect both availability and accessibility to needed health services when they occur.

• California rural hospitals are suffering from a shortage of physicians, nurses and other health care personnel.

• California rural hospitals need access to capital to maintain physical plants which meet regulatory requirements. Hospital seismic safety requirements alone can add 10 percent to 30 percent to hospital renovation and construction projects. While these requirements are necessary, they increase the capital needs of California's rural hospitals.

• Due to California's diverse rural areas and the diversity of rural areas across the nation, regulatory agencies and third party payers must provide waivers and financial support for a variety of pilot alternative rural hospital models to assure the availability of health care to all citizens. ■

1990 Legislative Agenda Solutions

• Eliminate the urban/rural differential by 1991.

• Appropriate funding for the establishment of the Essential Access Community Hospital (EACH) and the Rural Primary Care Hospital (RPCH) by 1991 and coordinate these programs with states that have established similar programs at the state level.

• Exempt rural hospitals from FTC regulations that may arise from mergers, acquisitions, consolidations or other cooperative efforts with other rural health care facilities.

• Establish programs that will assist rural hospitals in recruiting physicians and nurses through: 1) federal income tax incentives 2) additional Medicare payments to rural primary care physicians, and 3) reauthorization of the National Health Service Corps grant and loan programs.

• Through the federal Geographic Classification Board, establish a means through which hospitals in rural areas, that are paid at the small urban rate with a disproportionate Medicare volume, may access programs that are presently only available to hospitals paid at the rural rate.

CAHHS
CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HOSPITALS
SUMMARY 1989 UTILIZATION AND FINANCIAL INFORMATION

UTILIZATION

DISCHARGES INCREASED LESS THEN 0.1%
- Medicare utilization increased 3.0%
- Medi-Cal utilization increased 5.0%

OUTPATIENT VISITS INCREASED 4.1%

LENGTH OF STAY REMAINED STABLE AT 6.6 DAYS

OCCUPANCY INCREASED FROM 60.8% TO 62.5%

FINANCIAL PERFORMANCE

NET INPATIENT REVENUES PER CASE INCREASED 6.9%

INPATIENT EXPENSE PER CASE INCREASED 5.8%

PRETAX PATIENT MARGINS, FOR THE FOURTH CONSECUTIVE YEAR REMAINED IN THE RED -2.6 PERCENT.

IN PPS-5 HOSPITAL MEDICARE MARGINS FELL TO .4 PERCENT, MORE THAN 60 PERCENT OF THE HOSPITALS LOST MONEY ON THEIR MEDICARE BUSINESS

THIRTEEN TRAUMA CENTER CLOSED.

UNCOMPENSATED CARE COSTS - 5.2 MILLION CALIFORNIANS WITHOUT HEALTH INSURANCE - 21.6% OF THE NON-ELDERLY

TOTAL UNCOMPENSATED CARE COSTS INCREASED TO OVER $3.1 BILLION: A 9.1% INCREASE

	1989 AMOUNT	INCREASE OVER '88
MEDICARE	$ 647,000,000	3.4%
MEDICAL	1,169,000,000	6.8%
BAD DEBTS	722,000,000	9.5
CHARITY	564,000,000	20.7%
	$3,102,000,000	9.1%

CAPITAL

CAPITAL EXPENSE REMAINED STABLE AT 7.2% OF TOTAL EXPENSES

SOURCE: FY 1984-1987 State Annual Disclosure Data; CY 1988-1989 State Quarterly Financial and Utilization Data.

Representing California Hospitals and their Health Systems
1201 K Street, Suite 800 • Post Office Box 1100 • Sacramento, CA 95812-1100 • 916 443-7401 • Fax 916 552-7596

HCFA, AHA maneuver on Medicare capital reimbursement

Regulation to fold category into PPS still months from release

by Erich Eichner
HealthWeek Chicago Bureau

WASHINGTON—Hospital officials nervously await the debut of a new Medicare regulation on capital reimbursement, but officials close to the government effort say the new rule, which was due to be announced this summer, may not emerge until November.

Health Care Financing Administration officials won't say when the new regulation will be unveiled.

HCFA is "spending a lot of time examining different models," said Wendy W. Herr, director of regulatory issues with the Healthcare Financial Management Association, in Westchester, Ill. "That is OK with me. I'd rather they take their time with it."

> ■ "THERE IS just no [capital reimbursement] formula that works as well as the pass-through."
>
> *Kenneth Raske, Greater New York Hospital Association*

All hospital eyes are on Wilensky and HCFA because of Congress' 1987 order that the agency write a new regulation to fold Medicare capital payments into the prospective-payment system. The new regulation will spell the end of the cost-based system that covers 85 percent to 97 percent of hospitals' Medicare-related capital expenses.

"This is not as big as the shift to PPS, but it is probably second after that," said Glenn N. Wagner, director of municipal research at Mabon, Nugent & Co., a New York bond firm.

Last year capital spending jumped 28 percent, to $15 billion. Meanwhile, HCFA last year approved one-third of that amount, or about $5 billion in Medicare capital spending.

This year total capital spending is expected to climb 27 percent, to $19.3 billion, according to a recent survey by Shearson Lehman Hutton, a New York investment firm.

Moreover, Shearson found that 16 percent of hospitals are buying extra equipment this year because of Medicare capital fears.

The spending jumps are fueled by facility and equipment improvements in the burgeoning outpatient arena. If the new Medicare regulation cuts hospitals' capital funds, these areas would feel a heavy impact. Also hit hard would be hospitals with large debts brought about by earlier capital spending programs.

Hospital industry officials who have been consulted by HCFA about the new regulation said Wilensky has done a good job of listening to industry concerns. She has also conducted meetings on the regulation with private New York financiers.

However, they add that the administrator remains committed to making a break from the current cost-based system (see Insider Interview with Gail Wilensky, p.22). The industry wants to hold on to as many aspects of the current capital system as is legally possible, but there is disagreement on how much "wiggle room" HCFA has.

"We still think cost reimbursement is the way to go," said Paul Rettig, executive vice president of the American Hospital Association's Washington office.

"There is just no formula that works as well as the pass-through," said Kenneth Raske, president of the Greater New York Hospital Association. He added that New York's hospital sector is severely underbuilt and the need for additional capital is critical.

Annual spending jumps 10%

The $5 billion in 1989 Medicare spending represented about 9 percent of the program's $56 billion Part A budget. Government spending on Medicare capital payments has increased about 10 percent per year.

Herr said HCFA is trying to come up with a new capital model that discourages hospitals from increasing bed capacity. Wilensky has said she believes current figures that show four of every 10 staffed hospital beds empty should be reduced.

Many industry officials are skeptical of government efforts to change spending patterns, however, saying much of the Medicare capital money now being spent is going to pay off completed projects.

"To penalize hospitals for making good faith decisions 25 years ago is the incorrect way to go about this," Herr said. "All it does is send them into a crisis situation."

Although HCFA has held numerous meetings on the yet-to-be-released regulation, officials who spoke with HealthWeek admitted they have very little idea what the new capital rule will look like.

Among the alternatives under consideration, the rule could increase Medicare PPS payments by an unspecified percentage. Hospitals then would receive the capital money, even if such spending was not planned.

It is also possible that hospitals would earn the right to a certain amount of capital dollars depending on how much they were paid by Medicare through PPS. In this scenario, hospitals would receive the Medicare capital money only if projects or equipment purchases were planned.

Hospital officials said they do not expect the amount of Medicare capital money available to hospitals to change in fiscal year 1992, which begins on Oct. 1, 1991, when the regulation is mandated to go into effect. They say it is unclear whether Medicare capital cuts will be made in later years. In interviews Wilensky has indicated a phase-in period for the new regulation is likely. ■

PREPARED STATEMENT OF TONY VANG

Congresswoman Boxer, members of the panel: my name is Tony Vang. I am the Executive Director of Lao Family Community of Fresno, Inc., a non-profit organization that serves refugees and immigrants. I am here today to speak on behalf of the Southeast Asian refugee community in Fresno. Therefore, the health care needs and recommendations I will address are specific to this population, with an emphasis on children.

The Southeast Asian population includes political refugees and immigrants from Laos, Vietnam and Cambodia. As you know, the political refugees are here as a result of the Vietnam war.

Although they differ somewhat from one group to another, in general the health care beliefs of Southeast Asians do not correspond to those of Western medicine; for Americans and for Southeast Asians, unfamiliar healing techniques foster mistrust on both sides. Southeast Asians rely on traditional healing practices such as ancestor worship, herbalism, and acupuncture--practices that often conflict with Western medicine and its emphasis on science, germ theory, and viruses. On the other hand, Western health care practices often alienate patients from Southeast Asia, resulting in what Western providers consider to be non-compliance with medical advice.

The lack of trust escalates when Western care providers call in Child Protective Services (CPS) to force medical compliance. In some instances, this lack of trust and the refusal of SEA patients to accept medical advice and treatment has resulted in premature death and disability in women of childbearing age and children.

For example, because of lack of understanding and fear of surgery, a young Hmong woman died in childbirth rather than agreeing to a Cesarean section. Another graphic and tragic illustration of increasing mistrust, miscommunication and lack of health care education is the recent measles epidemic in Fresno County, which took the lives of 10 Hmong children.

Word of mouth plays an important role for people who may not be literate in their own languages. Negative, misinterpreted, often erroneous information on how patients are treated and why they receive a certain kind of treatment spreads quickly through the community--not only here in Fresno, but wherever refugees reside in the U.S. and in refugee camps overseas.

In resolving the health care problems facing Fresno County, we must address both the overall relationship between physicians and patients, as well as specific crises (such as the state of prenatal and delivery care, as well as our community experience during the measles crisis). Thus we need continuing education (for both Southeast Asians and for health care providers) to improve utilization of existing services. The Health Promotion project at Lao Family Community of Fresno has provided education in basic health information, hygiene and safety for Hmong, Lao, Cambodian, and Vietnamese refugees for the last five years; with 46,000 refugees speaking four major languages, however, current funding and staff allocations are inadequate. Second, we must build a partnership between community representatives and health care providers--a partnership that includes those in direct service. The recent effort on the part of the Health Department to forge such a partnership is a positive step toward this goal. Third, we must increase the number of bilingual/bicultural health care professionals. The number of trained interpreters and paraprofessionals serving the community and assisting in bridging the communication and service gap is woefully inadequate. Until

we have trained professionals from the Southeast communities, individuals will continue to receive inadequate services. Fourth, any effort must involve the community leaders. Communicating with and through the leadership will spread health care information to a far greater number than conventional methods. By taking these proactive steps in improving health care, Fresno will be much better prepared to deal with any crisis as it arises.

RECOMMENDATIONS:

1. Increase and guarantee continuous funding for trained interpreters and paraprofessional positions in the health care and social service sectors.
2. Provide funding for increased training opportunities for minorities in health and social service positions, including LVNs, RNs, and social workers.
3. Continue funding of programs that address basic community health education needs in culturally sensitive language via appropriate methods.
4. Address ways to increase the pool of Medi-Cal providers and reassess Medi-Cal guidelines that limit health care treatment. Many refugees depend on the welfare system, specifically Medi-Cal, for health care needs. There are a limited number of physicians who take Medi-Cal patients, resulting in less availability and access to health care.

PREPARED STATEMENT OF CAROL DAVIS

CONGRESSWOMAN BOXER, LADIES & GENTLEMEN:

MY NAME IS CAROL DAVIS AND I AM AN ELECTED DIRECTOR/TRUSTEE OF THE JOHN C. FREMONT HOSPITAL DISTRICT IN MARIPOSA COUNTY. FREMONT HOSPITAL IS THE ONLY HOSPITAL IN OUR RURAL MOUNTAIN COUNTY.

TODAY, I WILL ADDRESS THREE PROBLEM AREAS: NURSING, PHYSICIANS, AND BUILDING STRUCTURE.

NURSING IN A RURAL HOSPITAL DEMANDS MULTIPLE EXPERT SKILLS AND DIVERSE KNOWLEDGE OF EACH NURSE. MANY PEOPLE BELIEVE THAT BECAUSE A RURAL HOSPITAL IS SMALL IN SIZE AND BECAUSE IT DOES NOT CONTAIN MANY SPECIALITY DEPARTMENTS, THE KNOWLEDGE NEEDED AND THE SKILLS REQUIRED OF NURSES ARE LESS THAN IN LARGER HOSPITALS WITH HIGHLY SPECIALIZED DEPARTMENTS. THE OPPOSITE IS TRUE.

AT FREMONT HOSPITAL, THE REGISTERED NURSE WHO CARES FOR PATIENTS AND IS PROFICIENT IN ACUTE MED/SURG, PEDIATRICS AND OBSTRETICS ALSO HAS THE RESPONSIBILITY OF DIRECTING, BY RADIO, THE ACTIVITIES OF AMBULANCE PERSONNEL IN THE FIELD. A MOBIL INTENSIVE CARE NURSE (MICN) CERTIFICATION IS REQUIRED FOR THIS. THE HOSPITAL RECEIVES NO COMPENSATION FOR THIS SERVICE. THE AMBULANCE PATIENTS MAY BE ADMITTED TO FREMONT HOSPITAL BUT MORE FREQUENTLY ARE SENT ON BY AMBULANCE OR HELICOPTER TO A LARGER HOSPITAL THAT HAS SOPHISTICATED AND REVENUE GENERATING EQUIPMENT. RN'S MUST BE SKILLED IN EMERGENCY ROOM CARE AND HAVE THE KNOWLEDGE TO OVER SEE GERIATRICS PATIENT NEEDS. THE NURSE THAT POSSESS ALL OF THESE REQUIREMENTS CERTAINLY IS ENTITLED TO COMPENSATION EQUAL TO THAT PAID TO NURSES IN LARGER HOSPITALS. YET RURAL HOSPITALS RECEIVE AS MUCH AS 30% LESS COMPENSATION FROM MEDICARE FOR THE SAME SERVICES RENDERED IN URBAN HOSPITALS.

THUS THE HOSPITAL DOES NOT HAVE THE MONEY TO PAY THE WAGES THAT NURSES DESERVE NOR THE MONEY TO COMPETE IN THE NURSING SHORTAGE MARKET.

FREMONT HOSPITAL OPERATES A 24 HOUR EMERGENCY ROOM SERVICE WITH AN ER PHYSICIAN IN THE HOSPITAL AT ALL TIMES. THE PHYSICIAN IS PAID $ XX PER HOUR FOR 24 HOURS PER DAY. IN THE LARGER CITIES THE ER DOCTOR IS SEEING PATIENTS ALL THE TIME. WE SEE AN AVERAGE OF 9.5 PATIENTS PER DAY IN THE EMERGENCY ROOM WHICH DOES NOT COVER THE SIMPLE COST OF OPERATING THE EMERGENCY ROOM. WE ALL KNOW THAT EARLY TREATMENT FOR ACCIDENTS AND EMERGENCY ILLNESSES ARE ESSENTIAL. THE RESIDENTS IN RURAL AREAS AND VISITORS FROM THE CITY NEED TO HAVE EMERGENCY SERVICES AVAILABLE. YET THERE IS NO PLAN TO COMPENSATE FOR HOSPITAL LOSSES. THE RURAL HOSPITAL JUST GOES FURTHER IN DEBT AND/OR PAYS THE EMPLOYEES LESS.

MARIPOSA NEEDS MORE PHYSICIANS IN ORDER FOR ITS RESIDENTS TO RECEIVE ADEQUATE HEALTH CARE. RECRUITING PHYSICIANS IS EXPENSIVE. MOST DEMAND A SIX (6) MONTH SUBSIDY. THERE ARE NO FEDERAL PROGRAMS THAT I CAN FIND TO HELP. THE ONE PROGRAM I DID FIND FOR BUILDING DOCTOR'S OFFICES, REQUIRED A FIVE (5) DOCTORS GROUP PRACTICE!! GETTING FIVE (5) DOCTORS TOGETHER IN A CITY MAYBE EASY, BUT RECRUITING FIVE (5) DOCTORS AT THE SAME TIME IS UNREALISTIC IN A RURAL AREA.

THE LAST ISSUE IS BUILDING STRUCTURE. MARIPOSA HAS A HIGH RETIRED POPULATION. FREMONT HOSPITAL HAS A TEN (10)BED SKILLED NURSING UNIT BUILT 26 YEARS AGO. A SURVEY SHOWED THAT 54 ADDITIONAL SNF BEDS WERE NEEDED THE DAY THAT THE SURVEY WAS COMPLETED. MANY PEOPLE SUGGEST CONVERTING ACUTE CARE BEDS TO SKILLED NURSING BEDS. WE DO USE OUR ACUTE BEDS AS SWING BEDS, BUT FOR MANY REASONS IT IS AWKWARD, INCONVENIENT AND A STRAIN ON NURSING PERSONNEL. THE ROOMS ARE TOO

SMALL FOR TODAYS REQUIREMENTS. THERE IS NO PLACE TO STORE WHEELCHAIRS OR PERSONAL BELONINGS. THE BATHROOMS ARE NOT ACCESSIBLE TO WHEELCHAIRS. IS THE ANSWER TO REMODEL? NO. FREMONT HOSPITAL WAS BUILT 40 YEARS AGO UNDER THE HILL-BURTON ACT, FOR WHICH THE COMMUNITY IS GREATFUL. THE STRUCTURE IS A CLASS A BUILDING. THAT IS, IT IS BUILT OF POURED CONCRETE, BOTH THE OUTSIDE WALLS AND THE INSIDE WALLS. IT WILL RESIST AN EARTHQUAKE AND ALSO RESIST REMODELING. THE ONLY WAY TO MOVE A WALL IS WITH A JACKHAMMER, WHICH IS NEITHER FEASIBLE NOR COST EFFECTIVE. IT IS TIME FOR SELECTED RURAL HOSPITALS, THAT WERE BUILT UNDER HILL-BURTON, TO RECEIVE MODERNIZATION AND REPLACEMENT FUNDS.

THE DIFFICULITY THAT RURAL HOSPITALS HAVE HAD AND THE MULTIPLE CLOSURES DEMONSTRATE THE NEED FOR ASSISTANCE IN ORDER TO CONTINUE TO PROVIDE HEALTH CARE TO RURAL COMMUNITIES.

THANK YOU FOR LISTENING AND FOR CARING.

PREPARED STATEMENT OF BRUCE SATZGER

Congresswoman Boxer and Members of the House of Representatives Task Force on Human Resources:

My name is Bruce Satzger, and I am the Administrator of Valley Medical Center of Fresno. It is my pleasure to speak with you today on the subject of "Healthcare Crisis -Problems of Cost and Access."

May I begin by describing Valley Medical Center of Fresno and its role in healthcare access and delivery for the citizens of, not only Fresno County, but the citizens of the Central Valley of the State of California. Valley Medical Center is a County owned and operated institution. It is the primary provider for the indigents of Fresno County. It provides both primary care services as well as specialty and subspecialty services for the citizens of our Valley. It also is the Level One Trauma Center and, in fact, is the only Level One Trauma Center between, I believe, Bakersfield and Stockton. In this role it is a resource for all of the citizens of the Central Valley. Additionally, it is the Burn Center for the Central Valley, again, providing a resource for all of the citizens of this part of the state. As you are aware, these two services, Trauma and Burn are very high cost, requiring intensive levels of care services. They require highly trained physicians, nurses, technicians, technologists, as well as, the appropriate equipment. These high-cost services are not being reimbursed appropriately, and as a result we have seen a particularly acute crisis during the past twelve to eighteen months in the Los Angeles area. They at one point-in-time had approximately half of their Trauma Center's closed. If we were in that situation, and being the only one available in the central part of the state, one can see the potential havoc that would create.

Valley Medical Center also is a teaching institution, affiliated with the University of California, San Francisco Medical School. We have approximately 150 residents (physicians in training) in 10 different programs. These programs are primarily based at Valley Medical Center. There are many benefits to this area as a result of the teaching program. One of the major benefits is that the program is a feeder of physicians to the central part of the state.

Approximately one-half of our residents stay in the valley area to practice medicine. Also, another significant benefit is that the residents provide substantial care to our patients. From an economic perspective, the cost of a resident who, as we know, is a graduate physician is much less than having to hire separate licensed physicians or even other healthcare practitioners.

Following my discussion of the role of VMC leads me into what I will call - the necessity of developing a healthcare policy. We do not have a national or statewide healthcare policy. Is healthcare a right or is it a privilege. I believe everyone feels that it is a right. If that is the case, we are moving more and more away from it being a right to it being a privilege. And, if it is to be a privilege, then many individuals will not have access to healthcare.

As to cost of healthcare, what is an appropriate and acceptable cost level? Demand has increased dramatically over the years both on an inpatient and outpatient basis. The technological development in the healthcare arena is astounding. There have been significant procedures and equipment that have been brought to the healthcare scene that have had significant impact in the diagnostic and treatment of many health problems. This equipment is very costly but it has certainly had a marked impact on the improvement of healthcare.

To support this equipment and the other procedural developments, there is a need to have a highly trained group of allied health professionals. This not only includes nurses, but also laboratory technicians, pharmacists, respiratory therapists, nuclear medicine technologists, etc. These individuals are highly trained and as a result of that training are highly compensated. Additionally, the demand for these people is far exceeding the supply, which has had an adverse economic impact on salary costs for hospitals.

Hospitals are much more conscious and aware of the appropriate utilization and of their resources and services. The Quality Assurance and Utilization Review functions have improved dramatically and I feel they have had a positive effect on efficiencies in healthcare delivery.

For our institution, two of the key reimbursement areas in the Medicare Program are the capital pass through issue and the educational reimbursement issue. We are an aging facility both as to structure and equipment. We definitely need access to capital as well as assured reimbursement.

If capital is added to the DRG formula, it will have a negative impact on an institution such as ours and if the reimbursement for both direct and indirect medical education continues to be decreased, we see a risk to the viability of the teaching program.

The Medicaid Program, which is called Medi-Cal in California, is woefully underfunded, particularly for outpatient services. In our area we are starting to see where it is very difficult for a Medi-Cal patient to be seen by a specialist or sub-specialist, outside of our institution. The physicians no longer want to see these patients because of the reimbursement situation. Also, more and more physicians are not wanting to be on emergency call panels in the emergency rooms of many hospitals. The federal role in the Medicaid program needs to be reviewed.

Another area that impacts us is the program dealing with reimbursement for aliens and immigrants. I believe the State Legalization Immigration Assistance Grant Program (SLIAG) is no longer going to receive federal support. This will have an acute impact on our area. Fresno and the Central Valley have a high percentage of Hispanic and Southeast Asian residents. Many of these individuals have come to this country as a result of various federal policies and initiatives. It is wonderful that we have opened our doors to these people, but the service and health needs are enormous. These needs are putting an economic burden on local communities which are having a negative impact on the economic well-being of local governmental agencies. Federal help is definitely needed in order to overcome a deteriorating local situation.

In conclusion, I certainly feel from my perspective, that of a County Hospital Administrator, that we are in a severe healthcare crisis and it is not improving but only getting worse and worse. Something will have to be done but thus far we do not appear to have the interest or leadership to solve this situation both at the federal level and particularly at the State level. The last State budget was a tragedy for healthcare for the poor of our state. We are more than happy to cooperate in the development of a solution but we need the interest and leadership of individuals such as yourselves. Again, thank you for allowing me this opportunity to speak with you.

PREPARED STATEMENT OF GEORGE BLETH

include the County of Fresno as one public agency in this state -- indeed, this country -- whose public-health services have been impoverished by a lack of commitment to the poor and uninsured by both the state and federal governments. I am certain you are by now aware that the State of California has just made this crisis more desperate by cutting close to 20 percent of Fresno County's health-care funds for FY 1990-91. This is just one reason I welcome this task force to Fresno today. We need your help.

I have served as Fresno County's Health Director for three years, with responsibility for our county's Public Health, Mental Health and Environmental Health services. My choices in this role have often been painful. Because of ever-dwindling state and federal health-care resources, I have found it is more and more difficult to meet the health-care needs of those whom we are charged to serve. The expanding demand for services from an increasing number of indigent and the working poor in Fresno County can not be met at the current level of state and federal funding.

As a health-care provider, the County of Fresno leads a precarious existence, not knowing from one year to the next what services will be funded by the state or the federal government. The most recent state cuts I mentioned demonstrate the reality faced by local agencies for the past decade: a stable source of revenue has been wiped out. If we are required to cut clinic services -- incidentally, a scenario we were forced to contemplate this year -- the thousands of families that depend upon us would have few alternatives. They could make an appointment at the county hospital's already overcrowded outpatient clinics and wait for hours before they could be seen. They could seek services from one of the two or three publicly funded primary care clinics located in this county. Or they could forego care altogether. Too many, I believe, will choose the latter course. You know the consequences: more expensive acute-care treatment, usually at the county hospital's emergency room; babies born without adequate prenatal care; lack of childhood check-ups and failure to immunize children -- to name just a few.

Juggling what meager funds we do have has become commonplace for me. A few months ago, I was forced to pull already overtaxed Public Health Nurses from their normal duties to cope with the worst communicable disease epidemic to hit this county in decades. With insufficient funds to coordinate outreach activities to assure children are immunized, only 40 percent of those under age five have received their shots. The result? A staggering increase in the number of measles cases in Fresno County in just five years -- a jump from 10 in 1985 to 456 in the first six months of this year. Tragically, I must tell you ten deaths from measles have also occurred, all among Southeast-Asian children. Only the door-to-door, one-to-one canvassing of Southeast Asian neighborhoods by Health Department Public Health Nurses averted further misfortune. But while this effort was so critically needed, other folks in this county either were unable to benefit from our Public Health Nurses' services or were queued for the first nurse available to help them. I deplore the need for choices such as this. The rationing of health care is unacceptable, particularly in emergencies.

You are aware that a combination of state and federal funds finance prenatal care for the low-income. We need more help in this area as well. Of close to 16,000 births in Fresno County last year, 55 percent were born to mothers covered by Medi-Cal. Fifteen percent --over 2,000 babies -- were born to teenagers. Over one-quarter of all new mothers lacked adequate prenatal care last year. It should come as little surprise to you then that Fresno County ranks second in this state in the number of low-birth-weight babies born in the most recent year for which data has been collected (1988). All this, in spite of Comprehensive Perinatal Services funds and an annual state/federal allocation of approximately $57,000 for a prenatal-care guidance program specifically designed to outreach Medi-Cal-eligible pregnant women to encourage prenatal care. Once again I say to you: we need more! Clearly, our target population is 3 1/2 times higher than what the current funding levels allow us to reach.

Federal SLIAG funds have played a key role during the past few years, permitting eligible aliens to obtain medical care that would not have otherwise been affordable to them. Unfortunately, this funding source is short-lived -- due to expire in mid-1992. I ask that you promote continuance of SLIAG funding beyond the scheduled sunset date, recognizing that this group's ability to attain jobs at above-poverty-level wages will take time, particularly in the recession period which we appear to have entered.

Fresno County's health-care system faces special challenges as it serves another group of immigrants -- the Southeast Asian refugee community. Over 40,000 Southeast Asians now call Fresno County their home. Unfortunately, federal reductions in social-services and health-care funding will impede this group's assimilation into the mainstream of the community. The Health Department receives $63,000 in federal funds to screen newly arrived refugees and secondary migrants. A health assessment is conducted and each client is referred to a primary physician in the community for a complete physical exam and treatment as necessary. In addition, the department, using $14,000 in Centers for Disease Control funds, works with Southeast-Asian pregnant women who are hepatitis B carriers to assure that their babies are treated at birth so they too do not become carriers. I urge continued support -- and expansion -- of this fundamental method of protecting the public from communicable disease.

We are fortunate that our service delivery to the Southeast Asian community is coordinated through an active and responsible Southeast Asian Refugee Health Committee, comprised of leaders from the Lao, Hmong, Vietnamese and Cambodian community groups and the several social-service agencies addressing the needs of this population. They have been keenly interested in helping the department render the most effective service possible, and have particularly been of invaluable help to us during the measles epidemic. With this group's assistance, the county has applied for $150,327 in federal discretionary Target Assistance funds from the Office of Refugee Resettlement for expansion of a "Refugee Community Health Project." These funds will permit additional staff to outreach refugee families with basic health education which will safely allow refugees to identify when it is necessary to seek medical attention, especially at a hospital emergency room. Funds will also allow immunizations, blood-pressure checks with follow-up by a public health nurse, vision screening and CPR training.

As the AIDS epidemic continues, aggressive federal funding must be in place for both the research required to eradicate this disease and the treatment of those already afflicted. In addition, with over 200 AIDS cases reported to date in Fresno County, we must find the means to provide alternative non-acute, long-term care for AIDS patients other than in acute-care beds, particularly in publicly funded facilities. The federal government must be counted as a partner in the process of addressing this service gap.

Good health in America is, I believe, a shared responsibility among all levels of government. One jurisdiction alone -- be it local, state or federal -- cannot independently prevent disease and otherwise assure the public's health. Only by combining our special talents and our resources can we ever achieve our vision of appropriate, affordable care for all our citizens. The Committee for the Study of the Future of Public Health noted in its 1988 report The Future of Public Health that the federal government's role is diverse and certainly includes, ". . . (the) provision of funds to states to strengthen state capacity for services, especially to achieve an adequate minimum capacity . . ." I urge you to support this statement of responsibility and advocate for a strong federal financial commitment to public-health services for communities such as Fresno County.

PREPARED STATEMENT OF J.D. NORTHWAY, M.D.

Chairwoman Boxer; Members of the Committee.

Thank you very much for allowing me the privilege of sharing some observations regarding the cost of health care and its accessibility as it pertains to America's children.

Besides being the president and CEO of the only free-standing children's hospital in the rural United States, I am also a pediatrician. I understand from a clinical as well as business side the problems arising from the present health care delivery system, a system which expects minimum dollars to provide maximum care.

Our mission at Valley Children's Hospital is to provide comprehensive pediatric services to the more than 700,000 children living in the Central San Joaquin Valley regardless of the families' ability to pay for treatment. For 38 years we have been able to live that mission. But in the last two years that ability has become increasingly difficult and has reached a point where we are having to make some crucial decisions.

During a four month period this year, the hospital lost more than $1.4 million. This loss did not occur because we had empty beds; this loss occurred when our beds were overflowing. It occurred because reimbursement for children covered under Medicaid, or Medi-Cal as it is called in California, fell far short of covering the cost of care. This places us in a position of having to make difficult and heart-rending decisions regarding the delivery of health care to *all* children.

What things have led us to this point? First of all, Fresno County is the fastest growing county in California, growing at a rate of 4 percent each year with a significant percentage consisting of minorities with little or no education. The pediatric population has grown 8.5 percent, increasing the number of children covered under Medi-Cal by 22 percent. As this growth continues, we anticipate that 50 percent of all children living in Central California will be Medi-Cal eligible by 1995.

With each passing year - and literally each passing month - the numbers of Medi-Cal dependent patients treated at Valley Children's has risen. Presently our census averages 70 plus percent. During this past winter, our Medi-Cal census averaged 73 percent, and peaked at 76 percent. On a percentage basis, Valley Children's is the largest pediatric Medi-Cal provider in the state of California.

You would think a hospital that is overflowing and, in some cases, having to turn patients away because there were no more beds, wouldn't have a problem with cash flow. And that would be the case if reimbursement was equitable. But Valley Children's Hospital receives only 85 cents for every dollar of delivery cost. And because many children living in the Central Valley never receive the most basic health care and get to us when they are much sicker than they need to be, our staff uses 40 percent more manpower and dollars to

care for them than they did in 1987. That's a 32 percent increase in cost that we have had to shift to private pay patients.

What are some of the reasons children don't get health care sooner? Let me give you an example we have been faced with this year. Fresno County has a large Southeast Asian population - approximately 49,000 people. Among this population is the largest Hmong population in the United States - 29,000 and growing. These peoples' ideas about health care are vastly different from ours and, at times, lead to serious problems.

This past year during the nationwide measles epidemic, ten Hmong children died in our hospital because they had not been immunized. Their deaths accounted for 25 percent of total measles-related deaths statewide. Some of the reasons Hmongs have not immunized their children are based on religious beliefs, for example the belief that penetrating the skin allows the soul to leave the body. Because their beliefs are as important to them as our beliefs are to us, we find ourselves in a situation that does not allow us to practice medicine in the normally accepted fashion. We are unable to draw blood for lab work, do spinal taps or administer shots. Without immunization, which is an invasive procedure, the children had no resistance to the measles virus. Therefore, when children in the Hmong community were exposed to the measles virus, their families believed that they could be healed with traditional Hmong medicine administered by a shaman. When these attempts failed, they turned to us. We saved many of their children, but there were ten we could not keep alive.

Although this situation was limited in scope to one population and its particular religious beliefs, there are many barriers shared by the majority of the low income, government assistance dependent families we serve that seem simple but become huge obstacles to securing basic health care. Many of our families can't take their child to the doctor because they lack transportation or someone else to care for other children while they must be away. They wait until their child is ill beyond their ability to manage the care and then turn to us. Others don't have a primary care physician so they end up in the emergency room every time their child has a cough or a fever. Other families have the knowledge to access the health care system but don't have the means. They earn too much to qualify for Medi-Cal yet are unable to afford private medical insurance. They are truly caught in a vice because they know what they should do for their children, but economic restrictions keep them from doing it.

So how do we make basic health care accessible to all children? I believe two conditions must be met for health care policy to truly be effective. First, I believe eligibility criteria must be standardized nationwide. Many states have narrow eligibility requirements to which reasonable reimbursement rates are attached. Other states, like California, have reasonably broad eligibility requirements but fail to reimburse care providers at an equitable rate. Both systems are inadequate and deny access because they either purposely leave a large portion of the population without any coverage whatsoever, or they discourage providers, both physicians and hospitals, from participating in the delivery of health care. I propose that standardization of eligibility requirements will open access to all children.

Secondly, I believe reimbursement must pay for the cost of health care delivery and must be based on the proportionate share of care provided by each physician and hospital. Because Valley

Children's is a disproportionate provider of medical services, we receive a higher rate of reimbursement than do many other hospitals. But because our Medi-Cal census is so high, our negotiated reimbursement rate falls far short of paying for the cost of health care delivery. Because our patient mix is so out of balance, we are no longer able to cost shift enough to the private pay sector to make up the shortfall. Last year alone we provided $28 million in uncompensated care for children living in our valley. Not many businesses can remain viable with losses of that magnitude year after year. And while our mission is to provide care for *all* children, we find it harder and harder to meet this goal with each passing year.

I believe you will all agree that crisis medicine, or treating children when they are far sicker than they need be, is closely associated with increased hospital admissions and higher costs. If children had access to basic well child health care, I believe we would see a dramatic decrease in the numbers of hospital admissions. This means reimbursing primary care providers at a rate that allows them to accept Medi-Cal patients. Assuming that a child might visit a primary care provider six to eight times from birth to one year of age at $35 per visit, reimbursement at 100 percent would be $210-280 per year. This is less than one-third the average cost of one day's hospitalization, and less than one-sixth the cost of one day in a neonatal or pediatric intensive care unit. If primary care physicians are reimbursed adequately, there will be no reason for children to be denied access to basic health care, and the incidence of admission to hospitals will decline resulting in huge savings to both the state and federal governments.

In closing, let me offer some personal observations I've made this past year as a member of the National Commission on Children. I've traveled this country listening to parents, teachers, counselors, social workers, health care providers - anybody whose life or occupation brings them in contact with children. And I want to tell you that if things don't change, we're headed for disaster. What I keep hearing over and over is that a generation of adults today are not able to say with any conviction that life is going to get better for their kids. That's never happened in this country before. There are more and more people in our country who have given up because the chances of making it out of poverty are so overwhelming. That's awful. And one way we as health care providers, and you as policy makers can get this country back on track is to provide the basics for all children. Give them the chance to live healthy lives by providing them basic care. Help them learn how not to bring premature and drug-addicted babies into the world. Nothing would make me happier than to close our neonatal intensive care unit because all the young women in our Valley got such good prenatal care that none of them delivered premature or drug addicted babies whose futures are uncertain and whose ill health will most likely always be a deterrent to living a productive and useful life.

You have the ability to turn things around for this and future generations. You can do that by making access to care an inalienable right by standardizing eligibility requirements and reimbursing caregivers so they can keep on giving care. I urge you to provide all children the means to move toward their future by insuring access to basic health care.

PREPARED STATEMENT OF DR. ARTHUR SIEGEL, FRESNO, CA

We in the United States have been tolerating to an amazing degree an inadequate, failing healthcare delivery system and abuses such as people being turned away from health-care centers, the rising costs of health insurance, patient dumping, and unacceptable disparities between the health status of whites and people of color. The problem is more fundamental than simple increases in funding.

We speak of an "underfunded" health-care system when we spend more per capita on health care than any other nation in the world, 12 percent of our gross national product. The inadequacies of our system are not resolvable by increased funding, but a reallocation of the funds now being used.

A proposal worth of consideration has recently been made by Physicians for a National Health Program (in the January 12, 1989, issue of the New England Journal of Medicine). This group of over 400 distinguished physicians representing every state and medical specialty proposes the formation of a national health program similar to that now in existence in Canada, where all citizens receive health care at no out-of-pocket expense and only 8 percent of the GNP is used to pay for it.

Despite a 10-year campaign against "entitlements" by certain groups and individuals, most Americans believe that health care is a right, and that our health-care delivery system needs fundamental change.

In the area of health care we have a clear alternative to the status quo. Details vary, and while we may debate whether America should have a national health service (socialized medicine) or national health insurance (like Canada), and how it should be financed (taxes, employer contributions, etc.), the starting principal is that health care is an area where there is no place for profit.

This does not mean that health-care workers such as nurses, technologists, and nurses aides, as well as physicians, should not be well compensated for their training, experience, and responsibilities. A profit-driven health-care system is a moral offense, and besides we know it doesn't work.

There are substantial and responsible groups in this country that are working to bring about a more equitable, efficient, and decent health-care delivery system. Any further delay is intolerable.

Enclosure.

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A NATIONAL HEALTH PROGRAM FOR THE UNITED STATES

A Physicians' Proposal

DAVID U. HIMMELSTEIN, M.D., STEFFIE WOOLHANDLER, M.D., M.P.H.,
AND THE WRITING COMMITTEE OF THE WORKING GROUP ON PROGRAM DESIGN*

Abstract Our health care system is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. Patchwork reforms succeed only in exchanging old problems for new ones. It is time for basic change in American medicine. We propose a national health program that would (1) fully cover everyone under a single, comprehensive public insurance program; (2) pay hospitals and nursing homes a total (global) annual amount to cover all operating expenses; (3) fund capital costs through separate appropriations; (4) pay for physicians' services and ambulatory services in any of three ways: through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health program payment as the total payment for a service or procedure (assignment), through global budgets for hospitals and clinics employing salaried physicians, or on a per capita basis (capitation); (5) be funded, at least initially, from the same sources as at present, but with all payments disbursed from a single pool; and (6) contain costs through savings on billing and bureaucracy, improved health planning, and the ability of the national health program, as the single payer for services, to establish overall spending limits. Through this proposal, we hope to provide a pragmatic framework for public debate of fundamental health-policy reform. (N Engl J Med 1989; 320:102-8.)

OUR health care system is failing. It denies access to many in need and is expensive, inefficient, and increasingly bureaucratic. The pressures of cost control, competition, and profit threaten the traditional tenets of medical practice. For patients, the misfortune of illness is often amplified by the fear of financial ruin. For physicians, the gratifications of healing often give way to anger and alienation. Patchwork reforms succeed only in exchanging old problems for new ones. It is time to change fundamentally the trajectory of American medicine — to develop a comprehensive national health program for the United States.

We are physicians active in the full range of medical endeavors. We are primary care doctors and surgeons, psychiatrists and public health specialists, pathologists and administrators. We work in hospitals, clinics, private practices, health maintenance organizations (HMOs), universities, corporations, and public agencies. Some of us are young, still in training; others are greatly experienced, and some have held senior positions in American medicine.

As physicians, we constantly confront the irrationality of the present health care system. In private practice, we waste countless hours on billing and bureaucracy. For uninsured patients, we avoid procedures, consultations, and costly medications. Diagnosis-related groups (DRGs) have placed us between administrators demanding early discharge and elderly patients with no one to help at home — all the while glancing over our shoulders at the peer-review organization. In HMOs we walk a tightrope between thrift and penuriousness, too often under the pressure of surveillance by bureaucrats more concerned with the bottom line than with other measures of achievement. In public health work we are frustrated in the face of plenty; the world's richest health care system is unable to ensure such basic services as prenatal care and immunizations.

Despite our disparate perspectives, we are united by dismay at the current state of medicine and by the conviction that an alternative must be developed. We hope to spark debate, to transform disaffection with what exists into a vision of what might be. To this end, we submit for public review, comment, and revision a working plan for a rational and humane health care system — a national health program.

We envisage a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The proposed system would eliminate financial barriers to care; minimize economic incentives for both excessive and insufficient care, discourage administrative interference and expense, improve the distribution of health facilities, and control costs by curtailing bureaucracy and fostering health planning. Our plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States. We suggest that, as in Canada's provinces, the national

From the Working Group on Program Design, Physicians for a National Health Program, Center for National Health Program Studies, Cambridge Hospital–Harvard Medical School, 1493 Cambridge St., Cambridge, MA 02139, where reprint requests should be addressed to Dr. Himmelstein.

*This proposal was drafted by a 30-member Writing Committee, then reviewed and endorsed by 412 other physicians representing virtually every state and medical specialty. A full list of the endorsers is available on request. The members of the Writing Committee were as follows: David U. Himmelstein, M.D., Cambridge, Mass. (cochair); Steffie Woolhandler, M.D., M.P.H., Cambridge, Mass. (cochair); Thomas S. Bodenheimer, M.D., San Francisco; David H. Bor, M.D., Cambridge, Mass.; Christine K. Cassel, M.D., Chicago; Mardge Cohen, M.D., Chicago; David A. Danielson, M.P.H., Newton, Mass.; Alan Drublein, M.D., Cambridge, Mass.; Paul Epstein, M.D., Brookline, Mass.; Kenneth Frisof, M.D., Cleveland; Howard Frumkin, M.D., M.P.H., Philadelphia; Martha S. Gerrity, M.D., Chapel Hill, N.C.; Jerome D. Gorman, M.D., Richmond, Va.; Michelle D. Holmes, M.D., Cambridge, Mass.; Henry S. Kahn, M.D., Atlanta; Robert S. Lawrence, M.D., Cambridge, Mass.; Joanne Latomaik, M.D., Bronx, N.Y.; Arthur Mazer, M.P.H., Cambridge, Mass.; Alan Meyers, M.D., Boston; Patrick Murray, M.D., Cleveland; Vicente Navarro, M.D., Dr.P.H., Baltimore; Peter Orris, M.D., Chicago; David C. Parish, M.D., M.P.H., Macon, Ga.; Richard J. Pela, M.D., Boston; Leonard S. Rodberg, Ph.D., New York City; Jeffrey Scavron, M.D., Springfield, Mass.; Gordon Schaff, M.D., Chicago; Isaac M. Taylor, M.D., Boston; Howard Waitzkin, M.D., Ph.D., Anaheim, Calif.; Paul H. Wise, M.D., M.P.H., Boston; and William Zias, M.D., Cambridge, Mass.

health program be tested initially in statewide demonstration projects. Thus, our proposal addresses both the structure of the national health program and the transition process necessary to implement the program in a single state. In each section below, we present a key feature of the proposal, followed by the rationale for our approach. Areas such as long-term care; public, occupational, environmental, and mental health; and medical education need much more development and will be addressed in detail in future proposals.

Coverage

Everyone would be included in a single public plan covering all medically necessary services, including acute, rehabilitative, long-term, and home care; mental health services; dental services; occupational health care; prescription drugs and medical supplies; and preventive and public health measures. Boards of experts and community representatives would determine which services were unnecessary or ineffective, and these would be excluded from coverage. As in Canada, alternative insurance coverage for services included under the national health program would be eliminated, as would patient copayments and deductibles.

Universal coverage would solve the gravest problem in health care by eliminating financial barriers to care. A single comprehensive program is necessary both to ensure equal access to care and to minimize the complexity and expense of billing and administration. The public administration of insurance funds would save tens of billions of dollars each year. The more than 1500 private health insurers in the United States now consume about 8 percent of revenues for overhead, whereas both the Medicare program and the Canadian national health program have overhead costs of only 2 to 3 percent. The complexity of our current insurance system, with its multiplicity of payers, forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration and requires U.S. physicians to spend about 10 percent of their gross incomes on excess billing costs.[1] Eliminating insurance programs that duplicated the national health program coverage, though politically thorny, would clearly be within the prerogative of the Congress.[2] Failure to do so would require the continuation of the costly bureaucracy necessary to administer and deal with such programs.

Copayments and deductibles endanger the health of poor people who are sick,[3] decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones,[4] discourage preventive care,[5] and are unwieldy and expensive to administer. Canada has few such charges, yet health costs are lower than in the United States and have risen slowly.[6,7] In the United States, in contrast, increasing copayments and deductibles have failed to slow the escalation of costs.

Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of technology assessment and cost-effectiveness evaluation would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies, and other issues.

Payment for Hospital Services

Each hospital would receive an annual lump-sum payment to cover all operating expenses — a "global" budget. The amount of this payment would be negotiated with the state national health program payment board and would be based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and other costs, and proposed new and innovative programs. Hospitals would not bill for services covered by the national health program. No part of the operating budget could be used for hospital expansion, profit, marketing, or major capital purchases or leases. These expenditures would also come from the national health program fund, but monies for them would be appropriated separately.

Global prospective budgeting would simplify hospital administration and virtually eliminate billing, thus freeing up substantial resources for increased clinical care. Before the nationwide implementation of the national health program, hospitals in the states with demonstration programs could bill out-of-state patients on a simple per diem basis. Prohibiting the use of operating funds for capital purchases or profit would eliminate the main financial incentive for both excessive intervention (under fee-for-service payment) and skimping on care (under DRG-type prospective-payment systems), since neither inflating revenues nor limiting care could result in gain for the institution. The separate appropriation of funds explicitly designated for capital expenditures would facilitate rational health planning. In Canada, this method of hospital payment has been successful in containing costs, minimizing bureaucracy, improving the distribution of health resources, and maintaining the quality of care.[6-9] It shifts the focus of hospital administration away from the bottom line and toward the provision of optimal clinical services.

Payment for Physicians' Services, Ambulatory Care, and Medical Home Care

To minimize the disruption of existing patterns of care, the national health program would include three payment options for physicians and other practitioners: fee-for-service payment, salaried positions in institutions receiving global budgets, and salaried positions within group practices or HMOs receiving per capita (capitation) payments.

Fee-for-Service Payment

The state national health program payment board and a representative of the fee-for-service practition-

ers (perhaps the state medical society) would negotiate a simplified, binding fee schedule. Physicians would submit bills to the national health program on a simple form or by computer and would receive extra payment for any bill not paid within 30 days. Payments to physicians would cover only the services provided by physicians and their support staff and would exclude reimbursement for costly capital purchases of equipment for the office, such as CT scanners. Physicians who accepted payment from the national health program could bill patients directly only for uncovered services (as is done for cosmetic surgery in Canada).

Global Budgets

Institutions such as hospitals, health centers, group practices, clinics serving migrant workers, and medical home care agencies could elect to receive a global budget for the delivery of outpatient, home care, and physicians' services, as well as for preventive health care and patient-education programs. The negotiation process and the regulations covering capital expenditures and profits would be similar to those for inpatient hospital services. Physicians employed in such institutions would be salaried.

Capitation

HMOs, group practices, and other institutions could elect to be paid fees on a per capita basis to cover all outpatient care, physicians' services, and medical home care. The regulations covering the use of such payments for capital expenditures and for profits would be similar to those that would apply to hospitals. The capitation fee would not cover inpatient services (except care provided by a physician), which would be included in hospitals' global budgets. Selective enrollment policies would be prohibited, and patients would be permitted to leave an HMO or other health plan with appropriate notice. Physicians working in HMOs would be salaried, and financial incentives to physicians based on the HMO's financial performance would be prohibited.

The diversity of existing practice arrangements, each with strong proponents, necessitates a pluralistic approach. Under all three proposed options, capital purchases and profits would be uncoupled from payments to physicians and other operating costs — a feature that is essential for minimizing entrepreneurial incentives, containing costs, and facilitating health planning.

Under the fee-for-service option, physicians' office overhead would be reduced by the simplification of billing.[1] The improved coverage would encourage preventive care.[10] In Canada, fee-for-service practice with negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved to be compatible with cost containment, adequate incomes for physicians, and a high level of access to and satisfaction with care on the part of patients.[6,7] The Canadian provinces have responded to the inflationary potential of fee-for-service payment in various ways: by limiting the number of physicians, by monitoring physicians for outlandish practice patterns, by setting overall limits on a province's spending for physicians' services (thus relying on the profession to police itself), and even by capping the total reimbursement of individual physicians. These regulatory options have been made possible (and have not required an extensive bureaucracy) because all payment comes from a single source. Similar measures might be needed in the United States, although our penchant for bureaucratic hypertrophy might require a concomitant cap on spending for the regulatory apparatus. For example, spending for program administration and reimbursement bureaucracy might be restricted to 3 percent of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable source of income. Such funding could also encourage the development of preventive health programs in the community, such as education programs on the acquired immunodeficiency syndrome (AIDS), whose costs are difficult to attribute and bill to individual patients.

Continuity of care would no longer be disrupted when patients' insurance coverage changed as a result of retirement or a job change. Incentives for providers receiving capitation payments to skimp on care would be minimized, since unused operating funds could not be devoted to expansion or profit.

Payment for Long-Term Care

A separate proposal for long-term care is under development, guided by three principles. First, access to care should be based on need rather than on age or ability to pay. Second, social and community-based services should be expanded and integrated with institutional care. Third, bureaucracy and entrepreneurial incentives should be minimized through global budgeting with separate funding for capital expenses.

Allocation of Capital Funds, Health Planning, and Return on Equity

Funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the national health program budget. The funds would be distributed by state and regional health-planning boards composed of both experts and community representatives. Capital projects funded by private donations would require approval by the health-planning board if they entailed an increase in future operating expenses.

The national health program would pay owners of for-profit hospitals, nursing homes, and clinics a reasonable fixed rate of return on existing equity. Since

virtually all new capital investment would be funded by the national health program, it would not be included in calculating the return on equity.

Current capital spending greatly affects future operating costs, as well as the distribution of resources. Effective health planning requires that funds go to high-quality, efficient programs in the areas of greatest need. Under the existing reimbursement system, which combines operating and capital payments, prosperous hospitals can expand and modernize, whereas impoverished ones cannot, regardless of the health needs of the population they serve or the quality of services they provide. The national health program would replace this implicit mechanism for distributing capital with an explicit one, which would facilitate (though not guarantee) allocation on the basis of need and quality. Insulating these crucial decisions from distortion by narrow interests would require the rigorous evaluation of the technology and assessment of needs, as well as the active involvement of providers and patients.

For-profit providers would be compensated for existing investments. Since new for-profit investment would be barred, the proprietary sector would gradually shrink.

Public, Environmental, and Occupational Health Services

Existing arrangements for public, occupational, and environmental health services would be retained in the short term. Funding for preventive health care would be expanded. Additional proposals dealing with these issues are planned.

Prescription Drugs and Supplies

An expert panel would establish and regularly update a list of all necessary and useful drugs and outpatient equipment. Suppliers would bill the national health program directly for the wholesale cost, plus a reasonable dispensing fee, of any item in the list that was prescribed by a licensed practitioner. The substitution of generic for proprietary drugs would be encouraged.

Funding

The national health program would disburse virtually all payments for health services. The total expenditure would be set at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program. Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution, since tax-based funding is the least cumbersome and least expensive mechanism for collecting money. During the transition period in states with demonstration programs, the following structure would mimic existing funding patterns and minimize economic disruption.

Medicare and Medicaid

All current federal funds allocated to Medicare and Medicaid would be paid to the national health program. The contribution of each program would be based on the previous year's expenditures, adjusted for inflation. Using Medicare and Medicaid funds in this manner would require a federal waiver.

State and Local Funds

All current state and local funds for health care expenditures, adjusted for inflation, would be paid to the national health program.

Employer Contributions

A tax earmarked for the national health program would be levied on all employers. The tax rate would be set so that total collections equaled the previous year's statewide total of employers' expenditures for health benefits, adjusted for inflation. Employers obligated by preexisting contracts to provide health benefits could credit the cost of those benefits toward their national health program tax liability.

Private Insurance Revenues

Private health insurance plans duplicating the coverage of the national health program would be phased out over three years. During this transition period, all revenues from such plans would be turned over to the national health program, after the deduction of a reasonable fee to cover the costs of collecting premiums.

General Tax Revenues

Additional taxes, equivalent to the amount now spent by individual citizens for insurance premiums and out-of-pocket health costs, would be levied.

It would be critical for all funds for health care to flow through the national health program. Such single-source payment (monopsony) has been the cornerstone of cost containment and health planning in Canada. The mechanism of raising funds for the national health program would be a matter of tax policy, largely separate from the organization of the health care system itself. As in Canada, federal funding could attenuate inequalities among the states in financial and medical resources.

The transitional proposal for demonstration programs in selected states illustrates how monopsony payment could be established with limited disruption of existing patterns of health care funding. The employers' contribution would represent a decrease in costs for most firms that now provide health insurance and an increase for those that do not currently pay for benefits. Some provision might be needed to cushion the impact of the change on financially strapped small

businesses. Decreased individual spending for health care would offset the additional tax burden on individual citizens. Private health insurance, with its attendant inefficiency and waste, would be largely eliminated. A program of job placement and retraining for insurance and hospital-billing employees would be an important component of the program during the transition period.

Discussion

The Patient's View

The national health program would establish a right to comprehensive health care. As in Canada, each person would receive a national health program card entitling him or her to all necessary medical care without copayments or deductibles. The card could be used with any fee-for-service practitioner and at any institution receiving a global budget. HMO members could receive nonemergency care only through their HMO, although they could readily transfer to the non-HMO option.

Thus, patients would have a free choice of providers, and the financial threat of illness would be eliminated. Taxes would increase by an amount equivalent to the current total of medical expenditures by individuals. Conversely, individuals' aggregate payments for medical care would decrease by the same amount.

The Practitioner's View

Physicians would have a free choice of practice settings. Treatment would no longer be constrained by the patient's insurance status or by bureaucratic dicta. On the basis of the Canadian experience, we anticipate that the average physician's income would change little, although differences among specialties might be attenuated.

Fee-for-service practitioners would be paid for the care of anyone not enrolled in an HMO. The entrepreneurial aspects of medicine — with the attendant problems as well as the possibilities — would be limited. Physicians could concentrate on medicine; every patient would be fully insured, but physicians could increase their incomes only by providing more care. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board. This simplification of billing would save thousands of dollars per practitioner in annual office expenses.[1]

Bureaucratic interference in clinical decision making would sharply diminish. Costs would be contained by controlling overall spending and by limiting entrepreneurial incentives, thus obviating the need for the kind of detailed administrative oversight that is characteristic of the DRG program and similar schemes. Indeed, there is much less administrative intrusion in day-to-day clinical practice in Canada (and most other countries with national health programs) than in the United States.[11,12]

Salaried practitioners would be insulated from the financial consequences of clinical decisions. Because savings on patient care could no longer be used for institutional expansion or profits, the pressure to skimp on care would be minimized.

The Effect on Other Health Workers

Nurses and other health care personnel would enjoy a more humane and efficient clinical milieu. The burdens of paperwork associated with billing would be lightened. The jobs of many administrative and insurance employees would be eliminated, necessitating a major effort at job placement and retraining. We advocate that many of these displaced workers be deployed in expanded programs of public health, health promotion and education, and home care and as support personnel to free nurses for clinical tasks.

The Effect on Hospitals

Hospitals' revenues would become stable and predictable. More than half the current hospital bureaucracy would be eliminated,[1] and the remaining administrators could focus on facilitating clinical care and planning for future health needs.

The capital budget requests of hospitals would be weighed against other priorities for health care investment. Hospitals would neither grow because they were profitable nor fail because of unpaid bills — although regional health planning would undoubtedly mandate that some expand and others close or be put to other uses. Responsiveness to community needs, the quality of care, efficiency, and innovation would replace financial performance as the bottom line. The elimination of new for-profit investment would lead to a gradual conversion of proprietary hospitals to not-for-profit status.

The Effect on the Insurance Industry

The insurance industry would feel the greatest impact of this proposal. Private insurance firms would have no role in health care financing, since the public administration of insurance is more efficient[1,13] and single-source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating the overhead and profits of insurance companies and abolishing the billing apparatus necessary to apportion costs among the various plans.

The Effect on Corporate America

Firms that now provide generous employee health benefits would realize savings, because their contribution to the national health program would be less than their current health insurance costs. For example, health care expenditures by Chrysler, currently $5,300 annually per employee,[14] would fall to about

$1,600, a figure calculated by dividing the total current U.S. spending on health by private employers by the total number of full-time-equivalent, nongovernment employees. Since most firms that compete in international markets would save money, the competitiveness of U.S. products would be enhanced. However, costs would increase for companies that do not now provide health benefits. The average health care costs for employers would be unchanged in the short run. In the long run, overall health costs would rise less steeply because of improved health planning and greater efficiency. The funding mechanism ultimately adopted would determine the corporate share of those costs.

Health Benefits and Financial Costs

There is ample evidence that removing financial barriers to health care encourages timely care and improves health. After Canada instituted a national health program, visits to physicians increased among patients with serious symptoms.[15] Mortality rates, which were higher than U.S. rates through the 1950s and early 1960s, fell below those in the United States.[16] In the Rand Health Insurance Experiment, free care reduced the annual risk of dying by 10 percent among the 25 percent of U.S. adults at highest risk.[3] Conversely, cuts in California's Medicaid program led to worsening health.[17] Strong circumstantial evidence links the poor U.S. record on infant mortality with inadequate access to prenatal care.[18]

We expect that the national health program would cause little change in the total costs of ambulatory and hospital care; savings on administration and billing (about 10 percent of current health spending[1]) would approximately offset the costs of expanded services.[19,20] Indeed, current low hospital-occupancy rates suggest that the additional care could be provided at low cost. Similarly, many physicians with empty appointment slots could take on more patients without added office, secretarial, or other overhead costs. However, the expansion of long-term care (under any system) would increase costs. The experience in Canada suggests that the increased demand for acute care would be modest after an initial surge[21,22] and that improvements in health planning[8] and cost containment made possible by single-source payment[9] would slow the escalation of health care costs. Vigilance would be needed to stem the regrowth of costly and intrusive bureaucracy.

Unsolved Problems

Our brief proposal leaves many vexing problems unsolved. Much detailed planning would be needed to ease dislocations during the implementation of the program. Neither the encouragement of preventive health care and healthful life styles nor improvements in occupational and environmental health would automatically follow from the institution of a national health program. Similarly, racial, linguistic, geographic, and other nonfinancial barriers to access would persist. The need for quality assurance and continuing medical education would be no less pressing. High medical school tuitions that skew specialty choices and discourage low-income applicants, the underrepresentation of minorities, the role of foreign medical graduates, and other issues in medical education would remain. Some patients would still seek inappropriate emergency care, and some physicians might still succumb to the temptation to increase their incomes by encouraging unneeded services. The malpractice crisis would be only partially ameliorated. The 25 percent of judgments now awarded for future medical costs would be eliminated, but our society would remain litigious, and legal and insurance fees would still consume about two thirds of all malpractice premiums.[23] Establishing research priorities and directing funds to high-quality investigations would be no easier. Much further work in the area of long-term care would be required. Regional health planning and capital allocation would make possible, but not ensure, the fair and efficient allocation of resources. Finally, although insurance coverage for patients with AIDS would be ensured, the need for expanded prevention and research and for new models of care would continue. Although all these problems would not be solved, a national health program would establish a framework for addressing them.

Political Prospects

Our proposal will undoubtedly encounter powerful opponents in the health insurance industry, firms that do not now provide health benefits to employees, and medical entrepreneurs. However, we also have allies. Most physicians (56 percent) support some form of national health program, although 74 percent are convinced that most other doctors oppose it.[24] Many of the largest corporations would enjoy substantial savings if our proposal were adopted. Most significant, the great majority of Americans support a universal, comprehensive, publicly administered national health program, as shown by virtually every opinion poll in the past 30 years.[25,26] Indeed, a 1986 referendum question in Massachusetts calling for a national health program was approved two to one, carrying all 39 cities and 307 of the 312 towns in the commonwealth.[27] If mobilized, such public conviction could override even the most strenuous private opposition.

References

1. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986; 314:441-5.
2. Advisory opinion regarding House of Representatives Bill 85-H-7748 (No. 86-269-MP, R.I. Sup. Ct. Jan 5, 1987).
3. Brook RH, Ware JE Jr, Rogers WH, et al. Does free care improve adults' health? Results from a randomized controlled trial. N Engl J Med 1983; 309:1426-34.

4. Siu AL, Sonnenberg FA, Manning WG, et al. Inappropriate use of hospitals in a randomized trial of health insurance plans. N Engl J Med 1986; 315:1259-66.
5. Brian EW, Gibbens SF. California's Medi-Cal copayment experiment. Med Care 1974; 12.Suppl 12:1-303.
6. Iglehart JK. Canada's health care system. N Engl J Med 1986; 315:202-8, 778-84.
7. *Idem*. Canada's health care system: addressing the problem of physician supply. N Engl J Med 1986; 315:1623-8.
8. Detsky AS, Stacey SR, Bombardier C. The effectiveness of a regulatory strategy in containing hospital costs: the Ontario experience, 1967-1981. N Engl J Med 1983; 309:151-9.
9. Evans RG. Health care in Canada: patterns of funding and regulation. In: McLachlan G, Maynard A, eds. The public/private mix for health: the relevance and effects of change. London: Nuffield Provincial Hospitals Trust, 1982:369-424.
10. Woolhandler S, Himmelstein DU. Reverse targeting of preventive care due to lack of health insurance. JAMA 1988; 259:2872-4.
11. Reinhardt UE. Resource allocation in health care: the allocation of lifestyles to providers. Milbank Q 1987; 65:153-76.
12. Hoffenberg R. Clinical freedom. London: Nuffield Provincial Hospitals Trust, 1987.
13. Horne JM, Beck RG. Further evidence on public versus private administration of health insurance. J Public Health Policy 1981; 2:274-90.
14. Cronin C. Next Congress to grapple with U.S. health policy, competitiveness abroad. Bus Health 1986; 4(2):55.
15. Enterline PE, Salter V, McDonald AD, McDonald JC. The distribution of medical services before and after "free" medical care — the Quebec experience. N Engl J Med 1973; 289:1174-8.
16. Roemer R, Roemer MI. Health manpower policy under national health insurance: the Canadian experience. Hyattsville, Md.: Health Resources Administration, 1977. (DHEW publication no. (HRA) 77-37.)
17. Lurie N, Ward NB, Shapiro MF, et al. Termination of Medi-Cal benefits: a follow-up study one year later. N Engl J Med 1986; 314:1266-8.
18. Institute of Medicine. Preventing low birthweight. Washington, D.C.: National Academy Press, 1985.
19. Newhouse JP, Manning WG, Morris CN, et al. Some interim results from a controlled trial of cost sharing in health insurance. N Engl J Med 1981; 305:1501-7.
20. Himmelstein DU, Woolhandler S. Free care: a quantitative analysis of the health and cost effects of a national health program. Int J Health Serv 1988; 18:393-9.
21. LeClair M. The Canadian health care system. In: Andreopoulos S, ed. National health insurance: can we learn from Canada? New York: John Wiley, 1975:11-92.
22. Evans RG. Beyond the medical marketplace: expenditure, utilization and pricing of insured health care in Canada. In: Andreopoulos S, ed. National health insurance: can we learn from Canada? New York: John Wiley, 1975:129-78.
23. Danzon PM. Medical malpractice: theory, evidence, and public policy. Cambridge, Mass.: Harvard University Press, 1985.
24. Colombotas J, Kirchner C. Physicians and social change. New York: Oxford University Press, 1986.
25. Navarro V. Where is the popular mandate? N Engl J Med 1982; 307:1516-8.
26. Pokorny G. Report card on health care. Health Manage Q 1988; 10(1):3-7.
27. Danielson DA, Mazer A. Results of the Massachusetts Referendum on a national health program. J Public Health Policy 1987; 8:28-35.

ADVISORY COUNCIL
TO THE
FRESNO-MADERA AREA AGENCY ON AGING
2220 TULARE STREET, SUITE 1200
FRESNO, CALIFORNIA 93721
(209) 488-3821

August 30, 1990

The Honorable Barbara Boxer
U.S. House of Representatives
Cannon House Office Building, Room 307
Washington, D.C. 20515

Dear Representative Boxer:

This letter is submitted in order that its contents can be a part of the record of the Hearing which you chaired in Fresno on August 23, 1990 (topic: Health Care Crisis - Problems of Cost and Access, Task Force on Human Resources, Committee of the Budget, U.S. House of Representatives).

As you know citizens 60 years of age and older utilize a major portion of our nation's health-care services. Those of us who are official advocates of the aging were pleased, therefore, that a hearing on the vital topic of health-care was held in our community. We recognize moreover, the importance of providing an opportunity for local health-care providers to voice their concerns and recommendations. The Hearing, however, fell somewhat short of our expectations in at least two major respects.

First, we believe it was very unfortunate that no time was allocated in the Hearing agenda to health-care consumers and consumer advocates to make presentations. It is difficult to understand how health-care costs and access problems can be explored fully without a consumer input.
Second, the presentations from health service providers, identified problems which are generally recognized as ones of major concern to the consumer; the provider's solutions to these problems however, were essentially that of requesting more public funding under their existing health-care delivery systems. It is widely recognized that the present American health-care system is the most costly per person in the world. The U.S. nevertheless, ranks considerably behind other industrialized nations in life expectancy, infant mortality and long-term care assistance.

Many believe, as we do, that the need for a new approach to health-care is one of our nations foremost domestic problems. Studies and surveys indicate clearly that the need for a comprehensive health-care plan covering all citizens is advocated by an overwhelming majority of our citizens, a significant portion of the business community, many representatives from all levels of government, and elements of the medical profession and the insurance industry. We believe that the principles of a universal health care plan such as is included in the Pepper Commission Report and other reputable health-care reports should have served as points of reference for the August 23 Hearing.

We appreciate greatly the opportunity to have our point of view become a part of the Hearing record.

Very truly yours,

Wilbur D. Albright

Wilbur D. Albright
Chairperson
Legislative and Advocacy
Committee-Advisory Council
Fresno-Madera Area Agency on Aging

OPENING STATEMENT OF HON. MIKE ESPY

CONGRESSWOMAN BOXER -- I WANT TO THANK YOU FOR HOLDING THIS HEARING AND THE MANY OTHER HEARINGS YOU HAVE CONDUCTED AS CHAIRMAN OF THE HOUSE BUDGET COMMITTEE TASK FORCE ON HUMAN RESOURCES. THROUGH THE MANY MONTHS -- YOU HAVE ADDRESSED OUR PROBLEMS WITH MEDICARE, AIDS, BIOMEDICAL RESEARCH, VETERANS' HEALTH CARE AND THE WIC PROGRAM. YOUR WORK HAS FORCED MANY TO AWAKEN TO THE HEALTH CARE CRISIS OF OUR NATION -- A CRISIS THAT HITS OUR OLDEST AND YOUNGEST THE HARDEST.

I COME TO MODESTO, CALIFORNIA, FROM THE DELTA OF MISSISSIPPI -- A PLACE MANY CALL THE THIRD WORLD OF THE UNITED STATES. YOU KNOW WHAT I MEAN. I'M TALKING ABOUT A PLACE LIKE HUMPHREYS COUNTY MISSISSIPPI, WHERE 29 BABIES OUT OF EVERY 1,000 BORN DIE BEFORE THEY CAN BLOW THE CANDLE OFF THEIR FIRST BIRTHDAY CAKE.

IN MISSISSIPPI, WE HAVE MANY OF THE SAME PROBLEMS YOU HAVE -- NOT ENOUGH PRIMARY CARE PHYSICIANS, PATIENTS FALLING THROUGH THE CRACK OF OUR HEALTH CARE SYSTEM AND LEFT WITHOUT HEALTH INSURANCE OR LEFT WITH INSUFFICIENT HEALTH INSURANCE. IN MISSISSIPPI -- ABOUT 756,000 PEOPLE OR 30 PERCENT OF THE STATE HAVE NO HEALTH INSURANCE OR INSUFFICIENT HEALTH INSURANCE COVERAGE. 58 OF OUR MISSISSIPPI COUNTIES ARE HEALTH MANPOWER SHORTAGE AREAS. 14 HOSPITALS HAVE CLOSED SINCE 1985. I'M SURE THE STORY IS SIMILAR IN YOUR HOME COUNTY OF STANISLAUS.

NOW -- BESIDES BEING A MISSISSIPPIAN, I HAVE THE HONOR TO SERVE ON THE HOUSE BUDGET COMMITTEE AND CONGRESSWOMAN BOXER'S TASK FORCE.

BY COMING TO THIS HEARING TODAY I HOPE TO LEARN IN MORE DETAIL ABOUT YOUR SPECIFIC HEALTH CARE DILEMMA. AND WITH THE INFORMATION THAT WE GATHER HERE -- WE WILL GO BACK TO WASHINGTON AND SHARE IT WITH OUR COLLEAGUES. IN THIS CASE -- INFORMATION IS OUR AMMUNITION. THE AMMUNITION WE NEED TO CONVINCE OUR COLLEAGUES THAT WE MUST PLACE A PRIORITY ON HEALTH CARE. AND WHEN I SAY WE MUST PLACE A PRIORITY -- I DON'T MEAN JUST ALLOCATING MORE MONEY -- BUT RATHER ALLOCATING MORE TIME TO SOLVING THIS PROBLEM, MORE CONCERN AND MORE MONEY.

OVER THE PAST YEAR, WE HAVE WORKED HARD ON MANY PROPOSALS TO INCREASE ACCESS TO HEALTH CARE. IN BOTH THE HOUSE AND SENATE, WE PASSED A REAUTHORIZATION OF THE NATIONAL HEALTH SERVICE CORPS. WITH THIS BILL, WE HAVE REVITALIZED THE SCHOLARSHIP PROGRAM AND INCREASED THE MAXIMUM AMOUNT OF A LOAN REPAYMENT TO $35,000. WE ARE ALSO WORKING ON DIRECT MEDICARE REIMBURSEMENT FOR NURSES, THE ALLIED HEALTH PROFESSIONS ACT, AND MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS. ALL OF THESE PROPOSALS ARE AIMED AT GETTING HEALTH CARE TO AREAS MOST NEGLECTED.

AS A MEMBER OF THE BUDGET COMMITTEE, HOWEVER, I AM ESPECIALLY AWARE ABOUT OUR BUDGET CRUNCH. IF WE ALLOW SEQUESTRATION TO KICK IN ON OCT. 1, WE WOULD LOSE ABOUT 7,000 NATIONAL INSTITUTE OF HEALTH GRANTS. ABOUT $569 MILLION WOULD BE CUT FROM OUR FUNDS FOR PROVIDING HEALTH CARE TO VETERANS. AND AIDS FUNDING WOULD BE REDUCED BY $55 MILLION. THAT'S JUST SOME OF THE MINDLESS CUTS OF SEQUESTRATION. WE MUST BRING THE INFORMATION THAT WE LEARN FROM OUR FIELD HEARINGS BACK TO WASHINGTON TO SHOW OUR COLLEAGUES AND THE BUDGET NEGOTIATORS HOW SEQUESTRATION AND

MINDLESS CUTS WOULD DRASTICALLY HURT HEALTH PROGRAMS -- BUT MOST IMPORTANTLY -- WOULD DRASTICALLY HURT OUR MOST NEEDY.

AGAIN, I WOULD LIKE TO THANK CONGRESSWOMAN BOXER FOR CONDUCTING THIS HEARING AND I LOOK FORWARD TO HEAIRING FROM YOU -- THE FOLKS ON THE FRONT LINE OF OUR NATION'S HEALTH CARE CRISIS.

STATE CAPITOL
P O BOX 942849
SACRAMENTO, CA 94249-0001
(916) 445-8570

950 10TH STREET
SUITE 8
MODESTO, CA 95354
(209) 576-6211

Assembly
California Legislature

SAL CANNELLA
ASSEMBLYMAN, TWENTY-SEVENTH DISTRICT

COMMITTEES
AGRICULTURE
HOUSING AND COMMUNITY DEVELOPMENT
LABOR AND EMPLOYMENT
LOCAL GOVERNMENT
PUBLIC EMPLOYEES RETIREMENT AND SOCIAL SECURITY

PREPARED STATEMENT OF HON. SAL CANNELLA

Good Morning Congresswoman Boxer, and welcome to Stanislaus County, the City of Modesto and the 27th Assembly District. The 27th Assembly District covers all of Stanislaus County and a portion of Merced County.

The health care situation in California should be placed on the "critical list." Fundamental, comprehensive reform at the national and state level is necessary if we are going to break the cycle of runaway costs and declining access. Unfortunately, national and state action seems to be a long time coming. We must move to institute stronger cost controls, better resource planning and establish a comprehensive health care system that meets the needs of our constituents.

I am also concerned about the impact on employers who generally carry the majority of the cost of providing health care to their employees. A plan must be developed that provides affordable, quality care, while addressing the concerns of those who pay for the access to health care.

The crisis in the California budget is going to put an additional strain on an already over burdened system.

This is a national crisis and we look to the Federal Government for leadership in order to resolve this crisis. Hopefully, we can develop solutions from information and insight you gain from these hearings around the state.

Again, I welcome you to our community. There are many experts here to testify on the issues we face, and I will turn the agenda over to them.

STANISLAUS MEDICAL SOCIETY

P.O. Box 576007 • 2339 St. Paul's Way
MODESTO, CALIFORNIA 95357-6007
(209) 527-1704
FAX (209) 527-5861

JOHN C. PFEFFER M.D.
President

WILLIAM F. GRIFFITH M.D.
Secretary

PAUL O. HUMBERT JR.
Executive Director

PREPARED STATEMENT OF DR. JOHN C. PFEFFER

Madame Chairwoman:

I am John C. Pfeffer, M.D., President of the Stanislaus Medical Society and a practicing Obstetrician/Gynecologist in Modesto, California. I am here to testify on behalf of the Stanislaus Medical Society on the subject of access to health care, in particular as it relates to perinatal care in our county.

It is a privilege and an honor to be here today and to represent the Stanislaus Medical Society. I appreciate the opportunity to testify before the House Budget Committee Task Force on Human Resources and I further appreciate your personal interest and efforts in this area.

The general tone and setting of the medical community in Stanislaus County has previously been described to you in the other testimony presented today. The general problem of access to care and funding of same has been discussed as well. I will limit my comments to the special problem of access to perinatal care, recognizing that this is representative of the problem at large.

The issue of access to care as it relates to obstetrical and perinatal services in our county has reached crisis proportions. Our county facility, Scenic General Hospital, has had to limit access to care for obstetrical patients because of a tremendous shortage of manpower, space limitations and a desire to provide excellent care to fewer patients rather than to provide substandard care to many.

One of the major issues regarding access to care in our county is the growing numbers of patients who are either dependent upon the state to be a third party payor, ie Medi-Cal, the truly medically indigent patients or the "working poor", who are unable to afford insurance, yet not poor enough to qualify for state or federal assistance. As a result, these segments of the population cannot afford private obstetrical care.

There are many reasons as to why a crisis has been reached with respect to access to prenatal care in our county. Many local obstetrical practices are closed due to their busy practices, regardless of the type of insurance coverage. In addition, several practitioners have discontinued delivering obstetrical services within the last year altogether. Furthermore, the economics of accepting these patients into a private practice are such that it is a situation of a negative cash flow and as such, private practitioners are reluctant to accept large numbers of such patients into their care. Recent data has demonstrated that 62% of all physicians statewide provide services free or at reduced fees for patients in need. This activity accounts for 11% of their weekly practice hours. Because of increased numbers of such patients, combined with poor reimbursement and increased bureaucratic demands, providers of such care can no longer absorb the cost. In 1985, it was estimated that in San Francisco, each physician wrote off $51,000.00 per year as uncompensated care. In addition, there was an average of $32,000.00 per year which was discounted from the usual fees by government insurance programs. Certainly these numbers are significantly higher today. Because of the bureaucratic problems, such as a suspension of files or denial of claims that are rampant within our present system, all under the guise of accountability, it has made it distasteful and unprofitable for private practitioners to provide these services. I am sure that the number of physicians caring for such patients as well as the percentage of such patients allowed in their practices will diminish inversely as the paperwork and obstacles increase.

Because of the genuine concern that the physicians in Stanislaus County have had for the welfare of their patients, as well as the concern for the significant increases in maternal and neonatal morbidity and mortality that is associated with attending patients with no prenatal care and because of the litagation crisis that is present for all high risk medical specialties at this time, the practicing obstetricians in Stanislaus County have reached a consensus to formulate a plan of one years duration to provide care to these patients within the private community. Because of the physical and economic hardships that this presents to the individual practitioners however, this will only be a temporary solution to a long term problem. It does however afford us a window of opportunity to be able to establish a setting that will enable us to provide adequate prenatal and obstetrical services to these patients, while seeking a long term solution to this most pressing problem.

Our obstetrical referral project represents a unique marriage of the interest between the Stanislaus County Department of Health and the Stanislaus Medical Society. Each month the Department of Health Service will provide a link between obstetrical patients who are qualified for Medi-Cal and a practicing obstetrician in the private sector who will provide prenatal care and delivery services for these individual patients. As this program has just started on August 1, 1990, exact numbers are not available. It is however, estimated that approximately 80-100 women per month in Stanislaus County are now delivering their children without prenatal care through local emergency rooms and obstetrical units. Stanislaus County and the Stanislaus Medical Society have updated their list of

physicians who are willing to accept several additional Medi-Cal patients per month to provide appropriate care. With this new system, each of the participating obstetricians will receive equal numbers of referrals from the county health department on a monthly rotational basis. Following the delivery of obstetrical and postpartum cares, these patients will return to the county health system for their continuing health care.

Stanislaus County is proud of our tradition of volunteerism, social consciousness and public spiritedness. We are optimistic that our current efforts will not go unnoticed and will in fact improve perinatal care within the community. We are deeply concerned, however, that over the next several years this care will be limited because of the increasing patient populations that are unable to obtain adequate insurance coverage, the increasing population shift to our rural communities and with the decreasing reimbursement, physicians will be reluctant to continue working for less than their overhead cost. Additionally, it is becoming increasingly more difficult to entice physicians to continue their practices in obstetrics given the socioeconomic scenario currently present and the litagation crisis constantly rearing its ugly head.

In brief, there appear to be several major obstacles to providing appropriate perinatal services in our county. First of all is the liability crisis which I believe is directly responsible for the decreasing number of physicians willing to provide obstetrical services. Secondly, the underpayment of services rendered, often at less than overhead, make it economically unfeasible for physicians to provide such services. Third, the increased burden of cumbersome paperwork and lengthy appeals to billing suspensions and denials make the whole effort unrewarding and not worthwhile. Fourth, the major societal problems of substance abuse, particularly as they relate to narcotics and alcohol addiction, compound the already hign risk population who have not accessed themselves to prenatal care, leading to the increased risk to the mother and child medically and legally to the physician rendering care. Fifth and lastly, there is the constant problem of educating the public as to the benefits of providing prenatal care. Some women simply don't seek prenatal care, even if it is available to them.

The solutions to these problems are complex and varied. Several factors must come into play however. 1) Reimbursement for care rendered must be increased to appropriate levels. The usual Medi-Cal rate, approximately 35% of the usual and customary charges are below that needed to cover normal office overhead, malpractice insurance and the like. The recent decision to reimburse all obstetrical services at universal rates with a global fee, regardless of the risks encountered, the skill neccessary or the work done has further reduced this percentage. The Medi-Cal reimbursement rate for a surgical assistant on a cesarean section is so abhorrently low ($60.00) that it is increasingly more difficult to find physicians willing to render such assistance. Additionally, pediatric

and anesthesia services are more severely underpaid or simply not reimbursed. Therefore, certain services are not available to these patients and procuring appropriate pedicatric care is increasingly more difficult to obtain.

If the physicians providing the care cannot meet their cost and afford a small margin of profitability, the majority of us will simply not render this care in addition to the "tithing" that we are already providing. 2) A reduction in the bureaucractic demands and expenses is a must in order to make the care affordable to the state. This will allow the physician the opportunity to practice medicine in relative ease without the excess burden of paperwork that is often duplicated, confusing and cumbersome, contributing to data gathering that is poorly collated and often never evaluated. Recent estimates have shown that independent of the cost of patient care, the cost of running the American payment system may account for more than half the difference in cost between the Canadian and the U.S. health systems. 3) The litagation crisis needs to be addressed in a more effective manner by the legislature. Certainly, we would be most pleased with support of Senator Hatch's proposal of establishing, in a sense, a federal MICRA. In this regard, a major Harvard University study of malpractice in New York hospitals recently noted that over 80% of the cases filed by lawyers involved no negligence. In other words, over 80% of the patients who sued had no basis for doing so. Additionally, the most striking statistic in the study was that 99% of the patients received treatment without any negligence occuring. A 1% rate of negligence, I believe, is a statistic to be proud of. I can think of no other profession in the country that can boast such an outstanding record.

Currently the county hospital is our safety net. I would add one final plea to maintain appropriate reimbursement to the counties for the continued staffing of these facilities. Increased reduction in the reimbursement to the hospitals eventually translates to a loss of the safety net with an inabiltiy to maintain the level of care, the staffing personnel and the physical plant that are required to stay competitive in todays medical environment. Additionally, seed money is needed to help establish CPSP clinics and the like that will continue to allow us to extend care to these patients in a preventative manner-one that has been shown to be efficacious with respect to medical economics by decreasing morbidity, mortality and expenditures.

Lastly, I believe there must be a change in the public philosophy such that access to care truly relates to a privilege, being fortunate enough to live in our modern society in this wonderful country, rather than a right where such services must be provided at the whim of the individual, but at the extreme cost to the taxpayer.

In our county we have been fortunate enough to have the leadership, the wisdom and the beneficence of the local physicians that will allow us to search for solutions to the very serious problems confronting us. The assistance of you and your colleagues is desperately needed and most welcome.

Thank you Madame Chairwoman for allowing me the opportunity to present these comments to you today.

PREPARED STATEMENT OF BEVERLY M. FINLEY

Madame Chairwoman, I am Beverly Finley, Chief Executive Officer of Scenic General Hospital, Modesto, California. It is an honor to be here today to represent Scenic General Hospital and the County of Stanislaus' health care system on the subject of the Health Care Crisis - Problems of Cost and Access.

Scenic General Hospital is a 134 bed, acute care facility owned by Stanislaus County that has served the community for a century. From its beginning Scenic has been charged with a mission of providing care to those who cannot afford to pay. The hospital provides a full complement of services with the exception of labor and delivery and neurosurgery. Outpatient clinics which are located both on the hospital's main campus plus two satellite clinics care for over 130,000 patients each year. Ninety-five percent of our patients are insured under government sponsored programs. There is no room for cost shifting within this payor mix.

Scenic General Hospital is proud to be affiliated with the University of California at Davis, Family Practice Residency Program with a total of 21 Family Practice Residents. The residents receive their training from a hospital-based faculty group of sixteen physicians plus the part-time assistance of 45 community physicians. Forty percent of the program's graduates have remained in the Modesto community expanding access to medical care for the residents of the County.

The problems facing Stanislaus County and its health care system reflect the long history of a budget driven health care policy at the State and national levels that has eroded access to indigent patients. Despite years of declining margins produced by Medicare and Medi-Cal shortfalls, increased demand, increased costs and inflation, an eroding physical plant and capital equipment base, the Stanislaus County health care system, including mental and public health services, has been able to maintain its commitment to provide high quality care to its patients. However, our struggle has reached crisis proportions. The proposed reductions in the FY 1991 Federal budget proposal, if enacted, will escalate this crisis. The gap between revenues and expenses cannot continue to widen without dire consequences to access for indigent patients.

The Proposed Medicare Budget 1990-91

With the proposed Medicare cuts, teaching hospitals will be hardest hit. Teaching hospitals tend to serve more acutely ill patients as is typical of the indigent and low income population. In the past, teaching facilities had a higher than average Medicare margin based upon special adjustments which recognized the additional costs associated with physician training programs. This trend no longer holds true since the reduction in federal support covering medical education cost continues plus the 25% cut in capital payments.

Paying hospitals less than the full cost of a training program or the full cost of capital is not a sound public policy. The nation will continue to require an increased number of medical professionals. Improved technology is an investment that actually results in lowering the cost of health care. It is now possible to have gallbladder surgery on an outpatient basis through innovative techniques eliminating the need for a lengthy hospital stay. This technology must be available in teaching programs for the future needs of all citizens. Refusing to recognize the value of investing in medical education is an impractical approach that will have far reaching effects in terms of economics and standards of care.

The proposed 10% reduction in Medicare outpatient reimbursement is especially alarming. Hospitals have responded to the need to reduce costs by moving patient care to outpatient settings when appropriate, resulting in the most significant change in the health care delivery system during the 1980's. To further reduce inadequate reimbursement for outpatient care will place Medicare patients in the same dilemma now facing Medi-Cal patients. Access will be restricted or denied.

The Medi-Cal Program

In theory Medi-Cal patients in Stanislaus County can seek care from any provider whether hospital or physician. In practice this is not true. The low reimbursement level coupled with cumbersome billing requirements have gradually excluded nearly all private physicians in Stanislaus County from accepting Medi-Cal patients. Furthermore, because of the litigation process and increased costs, many physicians have stopped offering OB services reducing the number of providers available for this service. Scenic General Hospital and other hospital emergency rooms have become the safety net for Medi-Cal patients. The availability of a sub-specialty physician to see a Medi-Cal or indigent patient at Scenic is increasingly difficult because of inadequate reimbursement. The ramification of this poor reimbursement on access to Medi-Cal patients is dramatically illustrated by the obstetrical service provided at Scenic General Hospital.

In 1982 Scenic's OB services performed an average of 88 deliveries per month; and in 1989, 157 deliveries per month were made. Current data projects 300 deliveries per month by 1995. The number of high risk prenatal visits has increased over 50% per month during 1989. Much of this increase is directly attributable to the decrease in the number of providers who are willing to accept Medi-Cal patients into their private practices.

Scenic's capacity to accommodate this increased volume is restricted to its aging physical plant. Existing space restraints prohibit the expansion of OB clinics to accommodate the increased volume of women seeking OB care. During this time Scenic has lost the only full time OB\GYN on its hospital-based staff exacerbating the problem of access. After long and difficult debate concerning the need to limit access to ensure quality of care, the Coordinator of OB Services, Dr. Jesse Wilmes, began to set limits on the number of new patients that could be accepted into the clinics. However, because of the excess demand, appointments could not be given prior to the delivery date for many women.

During this time Dr. Wilmes was aided by Dr. John Pfeffer, President of the Stanislaus Medical Society, who participates in the residency teaching program. Because of the leadership of Drs. Wilmes and Pfeffer, a coalition with the community OB\GYNS was formed to accommodate the needs of pregnant women who cannot get realistic appointments into the Scenic OB clinic. Physicians have agreed to accept two to three Medi-Cal patients into their private practice on a rotation basis assuring the mother of prenatal care. This program began August 1.

The OB clinic is only one example of the problems of access for indigents and Medi-Cal patients in Stanislaus County. The pediatric clinics have a three week waiting time for appointments -- not a satisfactory delay when it is your sick child. A 48 day wait is necessary for a neurology appointment. Dermatology patients may wait for three months. Appointments in the residents' clinics average a three week wait. These waiting times are present in clinics that are exceeding capacity as much as 145% (OB) and 190% (Surgery). The delays in getting appointments and long waiting times to be treated on the day of appointment result in frustration for patients. No show rates approach 30% as patients seek treatment in the emergency rooms of local hospitals as they are not willing to wait for three weeks. Not only patients become upset. Hospital employees face daily frustration with angry patients, either those who have waited a long time to get in to see the doctor or who cannot get an appointment when they pursue health care services.

As a safety net hospital, Scenic has treated all patients who seek care through its services. However, the future looks bleak. The community's need has already exceeded this county hospital's resources as evidenced by limiting access for pre-natal care. Scenic has not experienced an operating margin that has allowed for physical plant replacement or renovation. The Medi-Cal reimbursement rate to Scenic General Hospital is less than 50% of charges for service to outpatients. In 1989-90 it is estimated that Scenic will have lost $1.8 million on its outpatient services, of which 55% are Medi-Cal. Much needed capital equipment and expansion for access cannot be realized for the absence of any funding source. As a result the hospital cannot accommodate the steadily increasing demand for service by Medi-Cal and indigent patients. But the effect of low reimbursement for Medicare and Medi-Cal services is only one portion of the financial crisis facing Scenic General Hospital. The State has been decreasing its reimbursement for health care to medically indigent patients since 1983.

Indigent Health Care

The vulnerability of the County's health care system can be demonstrated by the results of the current budget negotiations in the State. On Friday, the hospital had a proposed 1990-91 budget that showed a positive bottom line. On Monday, the budget showed an anticipated deficit of $2.3 million. This deficit is fully attributable to a reduction in Stanislaus County's State allocation of monies for medically indigent adults.

When the medically indigent adult program was transferred under the County's direction, the state funded the program at 70% of current costs of the program. It was believed that the County could run the program at less cost than the State. For Stanislaus County, the allocation was $6.6 million. Between 1984-88 there were no adjustments for inflation or increased demand. During 1989-90 the State reduced the allocation by $1.2 million with the promise of funding from the new program covering amnesty aliens from the State Legalization Immigration Assistance Grant Program (SLIAG). After aggressive pursuit of these promised new dollars, Scenic realized approximately $350,000, leaving a shortfall of $800,000. Contrary to the AB75 provisions that require the State to backfill any reductions in MISP funding with State and general funds we have learned that there is no appropriation to meet this legal obligation. In less than two years the indigent health care monies were reduced $3.1 million. A budget driven health care policy makes planning impossible. Plans to enhance revenues to offset the shortfall are deleted with the stroke of a pen at the State and national levels. Some programs, such as the Comprehensive Perinatal Services Program, reimburse OB services at a higher rate. Unfortunately, no seed monies are allocated to allow hospitals or clinics to develop and implement the program to secure additional revenues. The existing physical plant at Scenic General Hospital is overcrowded, overused and inefficient.

Some efforts have been made in addressing the issue of uncompensated care. Proposition 99 is a good example. The intent of this initiative has been interpreted in ways that eliminate its use for many hospital necessities. The mandate to expend an 18 month allocation within a 4 month period of time without the capability to carry funds into the next fiscal year forced hospitals into an expenditure plan that would have been altered with more time for planning. To impose this requirement with the full knowledge that indigent health monies were going to be cut, would suggest a lack of concern for the viability of the county health care system. The Tobacco Tax allocation will sunset in June, 1991, creating an opportunity for these funds to be further manipulated by the legislature for purposes other than intended by the initiative.

What does this mean to the low income, indigent, Medi-Cal and Medicare patients? The noose of low reimbursement is restricting their access to patient care. The low reimbursement and reduced allocations place Scenic General Hospital as well as the County's mental health and public health services in dire need of new funding sources. The governor and legislature gave counties new fee assessment powers to generate revenues to replace the indigent health care revenues from the State. Stanislaus County, like many other counties, faces severe cash problems of its own. The theoretical new revenues are subject to the countervailing pressures that exist in County government. Stanislaus County does not have a comprehensive policy to fund its health care system. However, it is clear that Scenic General and the departments of Mental Health and Public Health must obtain its appropriate share of these new revenues if we are to continue to meet the health care needs of our community. If Scenic cannot recruit and retain its staff or address its need for competitive salaries, if Scenic is not able to expand its purchasing power to acquire capital equipment replacement, and if Scenic cannot expand its revenue base to cover debt service to replace its aging physical plant, the safety net to indigents and government sponsored patients will be so constricted that access will be delayed for hours, weeks or months.

PREPARED STATEMENT OF SOLANGE GONCALVES ALTMAN

My name is Solange Goncalves Altman. I'm a staff attorney with California Rural Legal Assistance in Modesto. CRLA is a federally funded legal services program with 15 offices throughout rural communities in the state. We are actively involved in health advocacy for rural poor people. Most recently we were involved in a community effort to keep this county's hospital, Scenic General hospital open. Closure was threatened only last year.

As a legal services attorney I have witnessed firsthand the problems of cost and access faced by many low and middle income people. I have assisted clients in actually obtaining medical care, in challenging erroneous Medi-Cal determinations to obtain benefits to pay for care, and in arranging payment schedules on bills which will not be paid in your lifetime or mine. Of the dozens of clients I have represented I believe the experiences of Terry Brogdon, Pam Cobb and Erma Stepp exemplify the access problems to orthopedic, obstetric and dental care experienced by poor people in this county and state.

In August 1988, Terry Brogdon suffered a knee injury while working at his job as a drywall hanger. He thought his employer had Worker's Compensation which would cover his medical care and compensate him for his period of disability, but this was his first mistake. He soon learned that his employer had no Worker's Compensation and that he might never be compensated for his injury from the Uninsured Employers Fund.

Terry had no difficulty in getting treatment for his knee from a private orthopedist while the doctor thought that Worker's Compensation would pay for the bills. By the time surgery was scheduled, it was clear there was no Worker's Compensation. Unable to work because of his knee, Terry and his family applied and were granted public assistance and Medi-Cal. Terry offered to pay the doctor for the surgery with his Medi-Cal, but the doctor wouldn't accept it.

In March 1989, Terry attempted to get an appointment at the County Hospital, but he was told that new Medi-Cal patients were not being accepted only patients under the Stanislaus County Indigent Health Program. Under that county program services are provided exclusively at the county hospital. Scenic was forced to cut back orthopedic appointments then because one of their orthopedists was out on sick leave and as hard as they had tried they had not found a replacement. Medi-Cal patients were turned away because it was erroneously assumed that private orthopedists in the community would accept Medi-Cal.

In late March, Terry came to see me. I called every orthopedist listed in the telephone book inquiring whether Medi-al was accepted. Finally, one office in Turlock scheduled Terry for an appointment, but when he arrived for the appointment he was told that new Medi-Cal patients were not being accepted.

Unable to find an orthopedist in Stanislaus County, an appointment was made for Terry at San Joaquin General, the county hospital in Stockton, about 35 miles from Modesto. Though Terry felt it would be difficult to travel there for treatment, he was determined to get the care he needed.

Shortly after this appointment was made, I learned of a young orthopedist in Modesto, who had not been included in the specialist listing in the telephone book. This orthopedist was on contract at Scenic one day a week, and he agreed to see Terry at Scenic the first week of June. He ultimately performed surgery on Terry's knee in late July, and Terry was released for work by September 1989.

Terry's time off work cost the taxpayers approximately $7,200 in cash aid. It was only as a last resort that his family was forced onto public assistance. Being on public assistance was both a humiliating and humbling experience. The family is keenly aware how a medical emergency can force a middle class family on the public dole.

While Terry Brogdon was able to get the medical care he needed, it was only because of his and my persistence, and because he was lucky enough to have found a private orthopedist who would care for him. Other indigents requiring the services of specialists such as obstetricians have not been as fortunate.

Pregnant women are among those who have had a particularly difficult time in obtaining maternity care because of the paucity of obstetrician/gynecologists who will take Medi-Cal. In May Scenic General became overloaded and 10 pregnant women like Pam Cobb were turned away per week. Pam tried to find a private obstetrician to take care of her with no success.

In Stanislaus County, the number of family practice physicians serving more than five Medi-Cal patients dropped from five to three in 1985. State statistics reveal the shortage of obstetricians who take Medi-Cal is especially critical.

> From 1985 to 1987 there was a sharp decline in the number of obstetricians and family practitioners in private practice who were willing to provide maternity care to women on Medi-Cal. One study found that 3 out of 10 practicing obstetricians in California participated in the Medi-Cal program to the extent that the State paid for 10% or more of the deliveries in their practice. Meanwhile women on Medi-Cal have been giving birth to approximately 25% of all children born in California each year. 1

With limited access to obstetricians many poor women forego prenatal care. According to the California Department of Health Services most recent report (for calendar year 1984) only 61.3% of the women on Medi-Cal received any prenatal care during the first trimester. Stated differently, over 40,000 women on Medi-Cal were receiving no maternity care during the critical first three months of pregnancy.

The lack of prenatal care has translated into more high risk pregnancies and a higher infant mortality rate. According to a Children's Research Institute Study high risk pregnancies constituted one of every five births in California in 1984. California ranked 14th in the nation in preventing infant deaths with an infant mortality rate of 9.4% per 1,000 live births in 1983. In 1985, Stanislaus and Merced ranked at the bottom of the County Infant Mortality List.

In this county, a solution to the plight of pregnant women was found when 23 of the 24 private obstetricians in Stanislaus County each agreed to take up to three Medi-Cal patients per month for prenatal care to alleviate the crisis. To get this participation from private providers was an exemplary achievement-- a credit to the leadership of Scenic General Hospital and the Stanislaus County Medical Society.

These 23 private obstetricians taking Medi-Cal patients will help resolve the access problems faced by poor pregnant women in Stanislaus County in the short run. The concern I have is how long their assistance can be counted upon. For how long can we expect them to provide the extensive care high risk pregnant women require when they are paid a flat fee of $1010 by Medi-Cal

for all prenatal care including vaginal delivery. Medi-Cal makes no provision for the extraordinary services required by these high risk patients. There is no additional compensation for caesarian sections which in many of these high risk pregnancies can be medically necessary.

Though the $1010 Medi-Cal reimbursement rate for vaginal deliveries appears incredibly low, the rate was only $650 in 1987. The rate was increased because of Clark v. Kizer, a lawsuit filed by legal services advocates. Though the challenge to the Medi-Cal reimbursement rates for obstetrical care has been settled, the dental component of that lawsuit has not.

The lack of dentists who will accept Medi-Cal, sometimes known as Denti-Cal has created another tremendous access problem for poor people. Erma Stepp is an 81 year old client of my office who suffered enormously because of her inability to get proper dental care. Mrs. Stepp, a diabetic, needed a partial lower denture which was not an appliance covered by Medi-Cal regulations. Her need for the appliance was legally challenged as medically necessary because she could not eat without it. After litigation, Medi_Cal agreed to pay for the appliance, but even with Medi-Cal, Mrs. Stepp encountered much difficulty in acquiring the appliance because so few dentists accept Medi-Cal. Most dentists charge $1000 for a partial lower denture, but Medi-Cal only pays $289.00. Even so after much effort, one dentist in Stanislaus County was found who would make the appliance for her.

Provider participation in the dental program is also extremely low.

> Four out of 10 dentist in California refuse to treat any Medi-Cal recipients. Only 1 in 10 dentists draw more than 10% of their patients from Medi-Cal recipients. As a consequence, only 1 in 5 children on Medi-Cal receive routine preventive dental care each year; the statistics are even worse for adults.

As with obstetrics and orthopedics, low provider participation is a reflection of the absurdly inadequate reimbursement rates. In some instances the rates will not even cover the cost of materials yet alone the dentist's labor and malpractice premium. See Declaration of Bruce Valentine submitted in Clark v. Kizer.

In the three living examples provided of health access problems there are some recurring themes: 1) private providers don't want Medi-Cal patients because Medi-Cal reimburses them inadequately or not at all; 2) county hospitals like Scenic General Hospital are bursting at the seams. They have been expected to act as the safety net for patients who can't get treatment anywhere else; and 3) the longer medical care is delayed the more expensive it is to the taxpayer because medical expenses will be greater for more complicated conditions or because unemployability forces medically needy people to seek public assistance.

For the past 10 years there has been little federal leadership in attempting to come to grips with these problems. For the past 8 years there's been virtually no state leadership as well. To the contrary, more and more of the financial burden has been put on the backs of local government which lacks the tax base to provide meaningful solutions. It's time for some leadership. State and federal health care policies must change in several respects. Some of the changes that would improve health access would be:

1. Improvement of Provider Participation through Increased Medicaid/Medi-Cal Reimbursement Rates, Loan Forgiveness and Indemnity Programs. There must be more support for increased reimbursement rates. There is a direct relationship between changes in reimbursement rates and provider willingness to participate in public programs. One California study found that a 10 percent increase in the reimbursement rate was associated with a 6 percent increase in Medi-Cal participation by providers seeing 40 or more Medi-Cal patients annually. See Held & Holanan, Containing Medicaid Costs in an Era of Growing Physician Supply, 7 Health Care Fin. Rev. 49 table 3:53 (1985).

In order to enhance provider participation, Texas has enacted a program by which it will indemnify charity care providers whose practice constitutes more than 10% indigent patients. Programs like this should be monitored closely to determine their effectiveness in increasing access. If found effective consideration should be given to implementing such a program nationally.

Consideration should also be given to a Student Loan Forgiveness Program for physicians who devote 10% or more of their practice to indigent patients.

2. Funding Priority Must Be Given to Prevention Services. Several programs with demonstrated effectiveness have suffered dramatic cuts under the Reagan and Deukmejian administrations. The federally funded Women, Infants and Children Program which provides supplemental food to low-income pregnant and breastfeeding women and children under the age of five has suffered dramatically despite its record of proven effectiveness. Poorly nourished women are more likely to have high risk pregnancies. Of the over two hundred million dollars spent for hospital intensive care services for newborn children in California each year, it is estimated that one-third or $66 million could be saved with prevention-oriented prenatal care. (See Department of Health Services, Maternal and Child Health Branch, Budget Change Proposal, December 22, 1981.

3. Financial Support Must be Given for Expanded Clinical Services. When clinic appointments are unavailable, poor people resort to the emergency room for primary care, or medical care is foregone altogether. Both practices are more expensive in the long run.

Clinics like those at Scenic General Hospital and West Modesto Family Health Center could better serve more patients if additional funding was made available to expand their staff, and facilities.

One of the major provisions of Proposition 99, The Tobacco Tax, addresses the need for clinics and expanded pregnancy services. Unfortunately, the governor took away other state health care monies and substituted 99 funds. How much counties will have to expand clinical services is questionable now. It is also questionable whether those counties will be able to keep any 99 funds since the legislation was intended to supplement not supplant existing services.

4. Universal Health Care Coverage- Several proposals for insuring the uninsured were discussed in the report of the Pepper Commission to Congress. Legal services agencies in this state are supporting the Petris bill which provides universal access and is modeled after the system in place in British Columbia.

The time has come for major changes in our health policy as the dual system presently in existence denies many people access, and is not adequately addressing the needs of some 6 million uninsured people in California and a vast number of others in the nation.

PREPARED STATEMENT OF MICHAEL O. SULLIVAN

Thanks for the privilege to present information to you and your subcommittee related to health care access, federal financing, and cost needs of underserved populations especially women, children, and minorities in the Central Valley. My name is Mike Sullivan and for the past twenty-five years I have tried to improve the health care status of people in need both in the U.S. and in the developing third world.

I have three wishes that I know our Government can grant, however difficult the political realities:

1. That we put in place soon a National Health Plan, its financing weighted towards prevention and primary care, and assuring equal access to all U.S. residents. I personally believe there is much waste, inefficiency, and institutional and personal greed in the current system, and an inordinate and lopsided expenditure of resources paying for hospital and specialist care that must be redirected. Only when consensus is reached on a rational, accessible, and prevention and primary-care based health system, will we be in a position to control costs and limit negative outcomes such as high infant mortality which is a national disgrace.

2. That rural America's (and the San Joaquin Valley's) special health care needs be fully integrated into the agenda of a National Health Plan. Specifically, rural Americans must achieve equal access to physician resources, especially primary care M.D.'s. There are too many physician underserved rural communities in America caused by lifestyle needs of young M.D.'s, tremendous growth of female physicians, "competition" from foreign M.D.'s, and training methodologies in medical and residency programs creating dependency on high-tech equipment and facilities, and group practice association not available to rural communities. A National Physician Service or obligation will have to be incorporated into a National Health Plan.

3. And finally, that until my first two wishes are granted, that there be continued and increased grant financing to fill in the gaps of care needed by a growing underserved and uninsured population of high risk special people including the urban poor, the homeless, migrant farmworkers, the rural poor, those on Medi-Cal, poor pregnant women, the children of our poor, and refugees from Southeast Asia.

I am currently the Executive Director of the Merced Family Health Centers, Inc. (MFHC), a federal and state-supported Migrant and Community Health Center. We operate six clinic sites as a non-profit consumer-based corporation serving the poorest, most medically and dentally underserved populations in Merced and Stanislaus counties. Our mission is to provide quality primary health care services in the communities we serve regardless of language, financial, or cultural barriers.

Our agency has a workforce of over 110 full-time employees serving more than 25,000 individuals which accounts for over 90,000 visits annually providing them with basic medical, dental, and nutrition care including the services of primary care physicians and dentists, nurse practitioners, nurse midwives, registered nutritionists, and certified physician assistants. We support this clinical team with diagnostic laboratory and radiological services, pharmaceuticals, family planning and HIV education, childbirth classes, WIC, and total perinatal care, just to name a few. Our patients are 70% Hispanic, 10% Asian, 15% white, and 5% black. They are mostly farmworkers, but also include the homeless of Modesto, Southeast Asian refugees, the unemployed, and the "working" poor. In addition, we serve patients from five different language groups including Spanish, Hmong, Laotian, Vietnamese, and Cambodian. Likewise, our staff is more than seventy percent bilingual and bicultural. All of our educational materials, consent forms, etc. are translated for our patients. Nearly fifty-five percent of our patients are completely uninsured for health care services; for these patients, were it not for our agency, the only available sources of care would be the emergency room and outpatient departments of the local County hospitals in Merced and Modesto. Even for the thirty-five percent of our patients who are covered by Medicaid, options for receiving care elsewhere are extremely limited. Most private practice physicians refuse to accept Medicaid beneficiaries, or provide care only to a miniscule number of them. Thus, while we are regularly overwhelmed with a number of uninsured patients far exceeding our capacity to care for them, you should also be aware that, in the Valley, as in so many other communities across the nation, we face an ever-increasing number of Medicaid clients who see us as the only truly available source of care left to them.

I am proud of the fact that, over the 18 years of our existence, MFHC, as is true of CHC's nationwide, has provided comprehensive, continuous, community-based primary health care services to thousands of Valley residents who would otherwise have gone without care until they were seriously ill, or would have sought some form of episodic, non-continuous care from some other source. I know that, as a result of our presence and our work, our patients and the community as a whole is healthier and more productive; and that as a result of our emphasis on prevention, early diagnosis and treatment, and health promotion, we have saved them - and society as well - both money and, more importantly, lives.

But it is difficult, even for a Migrant Community Health Center like mine, to serve so many uninsured individuals and families despite the fact that we receive partial federal support to do so. I have seen a dramatic increase in waiting time for new patients and appointments for non-acute care increased from a reasonable one month period to three months.

In fact, the National Association of Community Health Centers reports that one of the most serious challenges facing health centers today is the ever-increasing number of people seeking services. New waiting lists are averaging between 15 and 28 percent of the current patient enrollment. Health centers report a 300 percent increase in the number of pregnant women seeking care, thus placing significant pressure on their limited obstetric services. In rural areas, closures of hospitals and physicians' offices have left entire communities in great demand of health care services. Between 1986 and 1987, rural centers had a 7.8 percent increase in the number of patients; of these, 83 percent were uninsured. And, while demand for services has increased significantly, grant funding for centers has decreased over time. Centers are operating at the same level of funding in 1989 as they were in 1987. In fact, 1989 funding is 25 percent lower than 1981 levels after adjustment for inflation.

Despite these difficulties, which might well cause others to give up or quit, or perhaps because of them, I believe that we have done an outstanding job of meeting the health care needs of the neediest in our community; and in that I believe we exemplify the mission and purpose of the Community and Migrant Health Center programs from their very inception - to reach out and serve those most in need among us; to do so with dignity, respect and attention to their special needs; to make access to basic primary care possible for them; and to make a fundamental change in the way our patients view health care.

Our experience has taught us much, and we have tried to learn from it. But one important thing that it has taught me is that when you begin to talk about, or to consider options for improving access to care for people who are not in the mainstream of health care today, it's not enough to focus on how the bills will be paid, or by whom. If you are truly interested in improving the HEALTH of these populations - whether they be uninsured, low-income, minority, non-English speaking, homeless, substance abusing, HIV-infected, or whatever - then it is imperative that you focus on WHERE they will go for care, not just on who will pay. We need more ambulatory care providers - more clinics -, staffed with qualified health professionals, to be access points for that care, and to coordinate and manage the patients' care through other providers, both specialty and inpatient services, as well. I happen to think that the Community Health Centers can and should serve as the perfect model for such a system, and with good reason:

- They have 25 years of proven experience in making health care accessible to underserved people and communities;

- They are community-based, and therefore responsive to their communities' needs and circumstances;

- They are closely monitored for adherence to strict requirements for management and financial systems;

- They must meet rigid standards for quality assurance and the qualifications of their clinical staffs, and for the provision of virtually important preventive and early diagnostic services; and

- They have compiled an outstanding record for the quality of the care they provide. Their impact of the health status of their patients and the communities they serve is unquestionable. Their ability to contain costs, to operate with a fixed budget and limited resources, and their success in substantially reducing the frequency of admissions and length of inpatient care are well proven.

Thank you for this opportunity to testify on behalf of the poor and uninsured patients of the Merced Family Health Centers, Inc.

PREPARED STATEMENT OF LINDA PERRY

Madam Chair and Members of the Task Force:

I would like to thank you for coming to Stanislaus County and providing us with the opportunity to share our views on the problems of cost and access for health care. I have been asked to testify regarding health care accessibility and federal funding needs from a child's health care perspective. I will address these issues focusing on three priority population groups: pregnant women, infants and adolescents.

Pregnant Women

Any discussion of children's health care issues must include consideration of issues regarding prenatal care. Lack of adequate care during pregnancy is a primary factor contributing to prematurity, low birthweight, birth defects and developmental delays and disabilities. Early and comprehensive prenatal care is of major importance in the prevention of these conditions. Access to prenatal care for low income women is a critical problem in Stanislaus County. Few physicians providing obstetrical services accept Medi-Cal (Medicaid) and there are few prenatal clinics to assume substantial care of Medi-Cal patients. According to a May, 1990, Sierra Foundation report, of 26 Northern California counties, Stanislaus had one of the most unfavorable ratios of physicians accepting Medi-Cal to women in the childbearing years who are Medi-Cal eligible, 1 physician to 1221 women. This is an increase from a ratio of 1:933 in 1988. The problem is compounded by the fact that most obstetrical services are centralized in the city of Modesto, the largest urban area in the county. Because over 45% of the births in Stanislaus County occur to women living in less urban areas, a significant proportion of low income women have to find transportation to the city to receive prenatal services. Due to this and other factors, including the continuing decrease of OB providers, the growing population of women in their childbearing years, the increase in number of women eligible for Medi-Cal and the increase in fertility rates, this access problem has become a Public Health crisis in Stanislaus County.

A major solution to this crisis is the establishment of additional prenatal clinics, especially in outlying areas where there are few providers serving low income women. This decentralization of services would allow these low income women access to care in their own community.

The State of California has a mechanism for funding the provision of services through its Comprehensive Perinatal Services Program. This program enables providers to give perinatal services, including psychosocial, educational, nutritional and medical assessments through a case management model. All services are reimbursable through Medi-Cal. As a CPSP provider, the Department of Public Health has shown that these clinics can generate enough revenue through Medi-Cal to become financially self-sufficient. However, the primary difficulty with this program has been the lack of money to seed the establishment of new clinics. Our experience in the past two years has shown that with $100,000 seed money, a clinic can be established and become self-sufficient in one year. Due to current state and county fiscal restraints, however, funding for new clinics is not available. Federal assistance, through the provision of seed money to establish new clinics, could greatly reduce the perinatal access problem.

Children

Infants and children from low income families experience problems similar to pregnant women regarding access to medical care. Because of the difficulty in finding primary care providers who accept Medi-Cal, many low income families do not have a physician and seek their care through emergency rooms. This is not cost-effective nor does it provide good continuity of medical care.

As with the access problem with prenatal women, decentralization of medical services would provide care to people where they live. The success of the WIC program model has shown that when services are easily available, people will utilize them and their level of health will be improved. Community clinics need to be established offering a variety of needed services to low income families, including WIC, Medi-Cal certification, medical care, dental care, well-child care (such as the Child Health and Disability Prevention Program), family planning and comprehensive perinatal services. If this were accomplished, the problems with access and the inappropriate use of emergency rooms for basic health care would be minimized.

Resources currently exist for reimbursing the majority of services that would need to be offered through the community clinics; these include Medi-Cal revenues and funding from both state and federal grants and programs. Again, the major problem remains the lack of availability of seed money to establish these clinic sites.

Adolescents

Adolescents also experience a variety of access issues relating to medical care. Needs for this age group include general health care, preventive health education regarding injuries, family planning, sexually transmitted diseases, AIDS and substance abuse; and mental health intervention relating to problems of emotional problems and issues of self-esteem. Here again, the solution is the establishment of community clinics which are easily accessible and which offer programs designed specifically to meet the needs of teens.

The group of adolescents with the highest level of need is the pregnant and parenting teen. Because of the multiple needs of this group, the best approach to service is the case management model. This is best exemplified by the Adolescent Family Life Program, an innovative approach to case management created and funded by the State of California. The success of this program has been statistically validated and has been recognized by the American Medical Association's Award for Excellence for intervention with pregnant teens. Through this program, pregnant and parenting adolescents are provided in-home case management for a period up to three years. Services focus on accessing medical care, education/vocation, adequate nutrition and psychosocial interventions such as child abuse prevention through parenting education. Unfortunately, relatively few adolescents can be served through this program: 86 per year in this County. With approximately 500 births per year and program services extending over a three year period, the possibility exists that at any one time, up to 1,500 young women may be in need of services. One option for increasing the numbers of teens who could receive this type of care would be to make AFLP-type case management services reimbursable through Medi-Cal. This option is currently being explored by the California Department of Health Services and will require federal support in order to be implemented.

Related Issues

Although access to health care is the major issue for all of these age groups, other issues are also of great concern. The existence of services does not assure in itself that care will be obtained.

Public outreach and education focused on the need for health care and its availability is essential. Education is also the key to the prevention of health problems before they occur. The availability of a 24-hour public transportation system is necessary in order for all low-income people to be able to obtain services when they need them.

As with other areas throughout the country, Stanislaus County is experiencing an increasingly severe problem with substance using pregnant women and their drug-exposed infants. There are not enough treatment programs to assist these women in overcoming their chemical dependency so that they may provide appropriate parenting and child care. To compound the problem, there are not enough resources through Public Health and other agencies to provide the in-home assessment and intervention needed for infants up to age three who were substance exposed prior to birth. It is essential for these infants to receive medical and developmental assessments on a regular basis in order to identify related problems and provide early intervention. This early intervention insures the best possible outcomes for these infants. Because of the magnitude of the drug problem, it is essential that the federal government assume a leadership role and work to assure that prevention and intervention services are funded.

Summary

As with other areas of urban and agricultural mix, Stanislaus County experiences a significant problem with access to health care. This greatly impacts the ability of pregnant women, infants, children and adolescents to obtain appropriate health services. Although we are striving to maximize the use of available resources, gaps in service still exist. In order to meet these needs, it is essential that the partnership between the federal government and local agencies be expanded.

PREPARED STATEMENT OF ANNA C. HUESCA

Madam Chair and Members of the Task Force:

It is a great honor to be here today.

I would like to begin by saying a little bit about myself. I was 14 years old and in the ninth grade when I got married. It was very difficult for me to go to school. Because of being so young and married, people tended to look at me differently, especially other teenagers at school. Then to make things even more difficult, I got pregnant before I turned 15 years old. This was really hard, since no one would hire me because I was a minor and I didn't have any skills. So I had no alternative but to go to "AFDC". This really hurt me at first because, even though I am poor, I have pride. Now I look back and I am so thankful I went there, because it was through them that I found out about the Teen Prenatal Clinic (TPC). This clinic really helped me because it did not make me feel intimidated. The reason for that is that other girls my age were there. The TPC referred me to WIC and that was a really great help, because it really gave me part of the nutrition that I needed to have a healthy pregnancy. I think that the WIC is an educational program because it teaches us how to eat healthy and how to take care of ourselves so that we could have a normal, healthy baby. I think that if I would have gone to a regular doctor instead of the Teen Prenatal Clinic, I probably would have not attended the appointments so often. It was the TPC who referred me to the Adolescent Family Life (AFLP) Program. I can't be thankful enough to this program because it helped me to have a higher self-esteem and to believe in myself. It also helped me to accomplish part of my goals. It was this program that introduced me to Independent Studies and through Independent Studies I was able to go to school and graduate.

If the AFLP would not have told me about Independent Studies, I think that all my dreams would have been shattered. I have three goals. One was to graduate. Thanks to Independent Studies and the AFLP Program, I was able to do that. My second goal is to be a medical assistant and I will accomplish that in four more months. My third goal is to be a doctor. I already registered to start in the spring semester at Modesto Junior College. I want to thank the government for giving grants and student loans, because it is with these grants and loans that people like me could accomplish their goals.

There is one thing I admire about the AFLP Program and that is their workers. For example, my worker, Rochelle Olson. She makes me feel like she really cares and she's not there just because it is her job. She proved that, because she went to my graduation and she didn't have to do that. That is why I believe that this program should be available to more teenagers so that they can be helped the same way I was helped.

Finally, at age 15, I had my baby girl. It was then that the AFLP referred me to the Nurturing Program. I really liked this program because I was able to talk about my problems and I was able to listen to other people's problems. That made me realize my problems were not so bad. Another thing that I liked about the class was the way the staff took care of our kids. Sometimes the kids would be crying and screaming. I really admired the way the workers handled it. Because they were so patient and caring, it made me want to be the same way.

After my baby was born, I started to have many problems because only a few doctors would accept Medi-Cal. In other places, doctors charge for Medi-Cal. One thing that I have had a problem with is that hardly any dentists accept Medi-Cal. The worst problem I have is that I don't drive and it is very difficult for me. If my baby would get sick, or if I would have any type of emergency after 6:00 o'clock, it would be hard for me to get transportation because that is the time the buses stop.

I would like to conclude by saying that I might just change my last goal and become an AFLP worker so that I could help other girls like I was helped.

I will end by saying "THANK YOU" to this wonderful country for its beautiful programs because, otherwise, teenagers like me would be forgotten.

Thank you.

PREPARED STATEMENT OF BARBARA ROSS

In preparing this testimony in addition to my own agency's personnel, I have contacted the following agencies for information:

- Stanislaus County Area Agency on Aging
- Stanislaus County Public Health Department
- Stanislaus County Alzheimer's Disease and Related Disorders Organization
- Visiting Nurses Association Home Health Agency
- Professional Reliable Nursing HOme Health Agency
- California Rural Legal Assistance
- Salvation Army Senior Services
- Stanislaus County Commission on Aging

Stanislaus County has an estimated population of 363,000. Of that population, 57,000 are seniors over 60 years and 17,800 are 75 years or older. Approximately 8,000 seniors are SSI recipients. The County has a large city, Modesto, and a large outlying rural area.

In dealing with seniors, especially low income seniors, it is important to remember that all issues are interrelated. For example, if a senior is experiencing health problems, they can be compounded by that person's living situation, income level, and ability to speak English. If the senior is a non-English speaking poor woman, living alone in an outlying rural area, her ability to reach appropriate medical care can be severely limited.

For anyone working with seniors, the same issues surface again and again. I would like to summarize these for you.

1. Physicians

Physicians in Stanislaus County are not accepting new Medi-Cal patients. The billing process is complex and time-consuming. Reimbursement is slow. Physicians express that it is not worth their time.

Other specialties, such as dental work and podiatry, suffer as well. New physicians only accept Medi-Cal until their practice is full.

2. Eligibility and Supplemental Coverage

We continually come in contact with seniors who are ineligible for Medi-Cal due to income or property; many of these people have a share of cost eligibility which does not help them on a day to day basis. At just above SSI level, this group of people cannot afford supplemental policies. Also affected are people below benefit level who have some insignificant property which they are unable to liquidate. For example, a person in a wheelchair in Modesto has difficulty selling a small trailer in Arkansas left to them by a family member. When basic choices need to be made, housing and food come first; medical care is often neglected. It is not unusual for an elderly person to return home from a doctor's office and throw a prescription away; they are to embarrassed to tell the doctor that they can't afford to get it filled.

3. Reimbursement

There are many services vital to keeping people at home which are not reimbursed by Medicare. Specifically, it does not pay for home health care which is considered "custodial". It does not pay for durable medical equipment for bathroom appliances. It does not pay for medications. Medicare is currently paying about 47% of an elderly person's medical bills. This makes supplemental policies a necessity. However, most supplemental policies pay for the portion left when Medicare pays; they do not pay for items or services denied by Medicare. The complexity of the billing process presents a severe hardship to clients at a time of stress and illness when they are least able to cope.

It is not unusual for vendors to bill clients directly for payment; as I have stated, the billing process is complex, payments are extremely slow. A local CRLA attorney shared with me that she has seniors coming in every week who have Medicare/Medi-Cal or supplemental insurance but are still being pursued by vendors for payment.

Medicare does not pay for convalescent care; this creates a situation where people must spend a healthy portion of their life savings on medical care before becoming eligible for Medi-Cal.

4. Accessibility of Services

Medical services, and specialized services in particular, are centrally located in Modesto. Seniors live everywhere in the county, including outlying rural areas. We have a tremendous problem in Stanislaus County in getting medical services to clients, and clients to medical services. The Public Health Department operates a Senior Preventive Health Care Program which provides outreach, education and health clinics. The program serves 700 seniors per year. Reaching outlying areas becomes more and more difficult as funding diminishes. At the same time, transportation for seniors, especially frail seniors, is extremely limited. The area on our county's western border is 20 to 25 miles away from Modesto. For an elderly person in that area to reach health services in Modesto, there is a bus once a week. For people who are unable to take the bus, there is no alternative. For an elderly person with a walker, a bus stop two blocks away might as well be 200 miles away - it is inaccessible. Even within Modesto, for frail elderly, the only method of transportation is a taxi or an ambucab. Our local service for the elderly has waits of up to 90 minutes at both ends of the ride, and a long ride with many "stops" for passengers. The frail elderly cannot tolerate the process.

5. Funding

Stanislaus County, and other smaller valley and mountain counties, are at a disadvantage in applying for grants. Our county is considered "urban" for funding purposes and therefore ineligible for "rural" money, even though we have many of the problems of a rural county. Programs and funding are clustered in the large metropolitan areas and seldom reach the valley. We do not have the large non-profit corporations and agencies which specialize in grant writing. Now and then a decision is made by a funding source to "ear mark" a valley or mountain site for a program, which leads to many needy areas competing for one site selection. When we are able to write grants to compete for programs, it is a grassroots effort of concerned people who share their time, energy and efforts to bring a needed service to the county. When we are awarded a grant, it is often a "drop in the bucket" as far as filling a need in concerned. For example, we were finally able to receive a grant for a Valley Regional Resource Center for Brain Impaired Adults through the State Department of Mental Health. Our regional resource center covers nine counties - approximately 7,200 square miles. In Modesto we have one staff person to cover a four county

area. When resources for respite were divided over this gigantic area, the amount for Stanislaus was so minimal as to be non-existent. The waiting list for this program grows daily. We have one Adult Day Health Care Center, serving approximately 30, and one Alzheimer's Day Care Center, serving 30. There are no other daycare centers. Funded respite in the area is limited to a handful of slots.

On the positive side, the programs currently in operation are extremely valuable and need to continue. The Mental Health Older Adult Program makes a large contribution to the senior community, both in direct service and in consultation and education. Public Health makes a real effort to provide preventive health care and education. Title III funded programs provide meals, information and referral and ombudsman services. The In Home Supportive Services Program serves 2,700 people within the county. The Multipurpose Senior Services Program serves 200 frail elderly. All of these programs are providing necessary service and need to be funded at levels which insure their continued effectiveness.

It is very important that while you are looking at health care needs you remember that all needs of the elderly are interrelated. If in-home services, nutrition programs, transportation, mental health, preventive health, housing and other vital services are not continued and augmented at the same time, costs of health related services will continue to rise.

In summary, primary health care needs are:

1. Physicians;

2. Preventive health programs, outreach and education in the areas where seniors live;

3. Expansion of in-home service options;

4. Health insurance coverage which is responsive to needs;

5. Simplification of the approval and billing process;

6. Transportation;

7. Programs for special needs groups such as Alzheimer's or stroke; day care, respite, counseling, and case management.

PREPARED STATEMENT OF DR. DENNIS HOBBY

Madam Chairman and members, my name is Dennis Hobby, and I am a practicing dentist here in Modesto. I am a member of the American Dental Association, the California Dental Association and the Stanislaus Dental Society. I am also the chairman of the Dental Advisory Committee of Scenic General Hospital, which is our county facility. In that capacity, I have volunteered time over the past three and a half years in what I am happy to say has been a successful attempt to establish a county dental clinic.

When I began my practice five years ago, I anticipated that there would be a place in my practice for all types of patients and reimbursement schemes. However, for reasons I will go into momentarily, I was unable to accept Denti-Cal patients. Therefore, I saw, and continue to see some patients on a charity basis; so my remarks today are from the perspective of a practitioner who, while not dealing with the Denti-Cal system per se, nonetheless observes the continuing problem of how poor patients, including those with Denti-Cal coverage, obtain care.

Five years ago, I perceived that the Denti-Cal program was in crisis. There were dentists in the Modesto area who accepted Denti-Cal patients and, while they may have complained about marginal reimbursement, seemed to be content in doing so. As a new practitioner, however, with all the start-up costs associated with equipment purchase, repayment of student loans, etc., and overhead of approximately 80%, I could not see a place in my practice for patients for whom reimbursement would mean a loss for every service rendered. I therefore never accepted Denti-Cal patients.

Over the intervening five years, the situation has worsened and my perception of a crisis in the Denti-Cal program has grown more profound. Very few dentists, and almost no pediatric dentists, will now accept new Denti-Cal patients. A report recently published by the California Policy Seminar stated that statewide, fewer than one in six general practice dentists will accept new Medi-Cal patients, and that many rural counties have no dentist who will accept new patients. In Stanislaus County, we currently have only six dentists willing to accept new patients, with an eligible population of close to 60,000.

In a state where only 17% of the population drinks optimally fluoridated water, early access to dental treatment, particularly preventive treatment, is especially important. The dental profession takes pride in its longstanding policy of stressing home care, regular checkups and cleanings, and fluoride treatments. The existing Denti-Cal program ignores those maxims in its criteria for care and instead seems to adopt an attitude that discourages treatment by

ethical practitioners while promoting the wholesale rendering of services by providers willing to look for the loopholes in the system.

Specific problems with Denti-Cal are:

1. Fees cover only two thirds of the dentist's overhead costs, meaning a financial loss for every service rendered. (Average dental overhead is in the 65-80% range.)

2. An inadequate scope of benefits which does not allow ethical practitioners to provide comprehensive, cost-effective care with an emphasis on prevention of disease.

3. An administratively complex claims processing system which denies one claim in every thirteen. This system requires excessive x-rays, burdensome written documentation for routine services, and additional postage on an oversized envelope.

The Policy Seminar's report cites these problems as reasons why Denti-Cal fails to meet federal medicaid requirements for adequate provider compensation and patient access to care.

I realize your mission at this hearing is not entirely to focus on problems of medicaid recipients, but before moving on, I feel compelled to publicly state my belief that the current Denti-Cal program cannot be "fixed" by continuing to tinker with it as has happened in the past several years. Tinkering has brought about a completely failed system that should be scrapped. In its place, I would hope to see a reasonable, cost-effective program that has the patient's welfare - not the government's pocketbook - in mind. And I believe that can be accomplished within the confines of a limited budget. In fact, that is our goal at the Scenic General Clinic: a cooperative effort between the profession and government. This will complement what our dental society has done through its Mid-Valley Dental Foundation, which annually donates $60,000 worth of care to needy children. (I have attached to this written testimony the executive summary of the Policy Seminar's report, for your information).

Now, let me touch briefly on the dental aspects of health care as a whole. The economics of dentistry are different from those of medical and hospital services, a distinction few policymakers recognize. One significant difference is in cost: dental care has not risen in cost at the rate medical care has; in fact, in the past 15 years, it has generally stayed below the CPI. Another equally important distinction is the nature of dental disease: it is preventable and, unlike some medical conditions, it will not heal itself without therapeutic intervention, which makes early diagnosis and treatment imperative and cost-effective. The need for dental care is universal and on-going, not episodic, and that need is highly

predictable. Patient cooperation and self-care are critical to successful dental care. These factors are essential when considering how to pay for universal dental care.

The delivery system in California is a good one, resulting in the highest standard of dental care in the world. Unfortunately, that standard of care is not uniformly accessible to the poor and those in long-term care facilities. I am proud to represent a group of caring professionals who willingly volunteer their time in schools and clinics, as I do, and who stand ready at all times to meet the challenge of changing our system. The burden of unmet need, however, is too heavy to be met entirely by the profession without assistance. We believe dental and medical care for the poor is a societal, community problem best addressed by cooperative efforts of the private sector and government.

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ACCESS TO DENTAL CARE FOR MEDI-CAL RECIPIENTS

By Peter C. Damiano, E. Richard Brown, Jeffrey D. Johnson, and James P. Scheetz

Access to dental services is important for the emergency treatment of pain and infection, the detection and diagnosis of oral diseases, the restoration of oral health, and the provision of preventive services. Regular check-ups, cleanings, sealants, and fluoride treatments can prevent the majority of oral health problems. These preventive treatments make it possible for young people today to grow up with fewer serious oral health problems.

However, access to dental services may not be available for many Medi-Cal eligible children and adults. Access to dental services for the poor is particularly important in California where only 17 percent of the residents live in areas with optimally fluoridated drinking water. In 1985, the Special Committee on Medi-Cal Oversight of the California Legislature heard testimony indicating that access to dental services for Medi-Cal recipients was inadequate due to declining participation by dentists in Medi-Cal. However, the degree of dentists' participation in Medi-Cal was unknown.

The four primary objectives of this study were to:

1. Determine the accessibility of dental services for Medi-Cal recipients.
2. Determine how Medi-Cal dental fee schedules compare with fee schedules for private dental practitioners.
3. Evaluate the perceptions of dentists toward Medi-Cal patients and toward the Medi-Cal program.
4. Evaluate the Medi-Cal dental referral program's ability to increase access to care.

Access to Medi-Cal dental services was measured in two ways. The first method was to determine the number of dentists who would accept new Medi-Cal patients. Dentists' participation was determined when research assistants called dentists as proxy Medi-Cal patients for a check-up appointment. The second measure of access was the amount of time these proxy Medi-Cal

California Policy Seminar
University of California
109 Moses Hall
Berkeley, CA 94720
(415) 642-5514
ATSS 8/582-5514

patients had to wait for a check-up appointment compared with a patient with private dental insurance. To prevent any financial loss, appointments made by the proxy Medi-Cal patients were canceled within two working days of the time of the call.

The fees paid by Medi-Cal were reviewed by comparing Medi-Cal reimbursement with fee schedules obtained from general practitioners, pediatric dentists, and a health maintenance organization (HMO). The dentists' perceptions of Medi-Cal patients and of the Medi-Cal program were determined using telephone interviews with a systematically subsampled group of the dentists who did and did not accept new proxy Medi-Cal patients.

The Medi-Cal dental referral program provides a toll-free phone number established by the Medi-Cal program to allow patients to call and receive the name of a dentist in their area who accepts new Medi-Cal patients. Proxy Medi-Cal patients were used to determine the availability of providers in all the counties in the state, how up to date the information provided by the referral program was, and how successful the program was in placing Medi-Cal patients.

MAJOR FINDINGS

1. Access to dental services for Medi-Cal recipients is very limited.

a. Only an estimated 16 percent of all general practice and pediatric dentists in California accept children as new Medi-Cal patients, and only 15 percent of all general practice dentists accept adults as new Medi-Cal patients. Both rural and urban areas have low provider participation, and many rural Medi-Cal patients have to travel a considerable distance because some rural counties do not have a single dentist who will accept them.

b. Access to Medi-Cal dental services was further limited by the fact that Medi-Cal patients had to wait almost 40 percent longer, on average, for their first appointments than patients with private insurance. The longer a patient has to wait prior to an appointment, the greater the likelihood that the appointment will be missed.

c. Access to care is also limited by dentists' criteria regarding the type of Medi-Cal patients they will accept. Four out of 10 dentists interviewed qualified their acceptance of new Medi-Cal patients to only certain types, such as those with emergency or denture needs.

d. The low number of providers participating in the Medi-Cal dental program has reduced access to dental care for children through the Child Health and Disability Prevention (CHDP) program. All Medi-Cal eligible children over the age of three and non-Medi-Cal eligible children under age 19 from families with incomes up to twice the poverty level are required to be referred annually to a dentist. Many local CHDP programs are having difficulty identifying dentists in their area who will accept eligible children for referral.

2. Medi-Cal fee schedules are considerably lower than those for private practitioners.

Medi-Cal fees were compared with fee schedules from general practitioners, pediatric dentists, and an HMO in California. On average, Medi-Cal pays less than half the fees established by the general practitioners and the HMO. In addition, Medi-Cal fees were estimated to pay only about two-thirds of the dentists' overhead costs. Thus, many dentists lose money when they provide services to Medi-Cal dental patients.

3. Dentist had several concerns about Medi-Cal patients and about the Medi-Cal program.

a. Although fewer than one in six dentists accepted new Medi-Cal patients, the majority of dentists interviewed indicated that they felt Medi-Cal was important for poor patients' access to dental care and that they would not be able to receive dental services without the Medi-Cal program.

b. Many dentists believe that the Medi-Cal program does not allow them to provide comprehensive

care. They cite the lack of reimbursement for a second cleaning or for the use of sealants, a clear plastic coating placed on the biting surface of children's back molars. The plastic fills in the deep grooves, protecting the teeth from cavities, which can begin in the grooves where it is difficult to clean.

c. Low reimbursable fees were the most important problem reported by 98 percent of the dentists surveyed, with little difference between dentists who accepted new proxy Medi-Cal patients and those who did not.

d. Dentists perceive the Medi-Cal dental program as administratively complex. A combination of problems such as denial of payment, complicated paperwork, and the need to obtain prior approval for many routine services was seen as very important in determining dentists' participation in the program. Although Medi-Cal has made some effort recently to make the program less complicated, such as eliminating the need to receive prior authorization before treating children for routine procedures, the perception among the dentists surveyed was that Medi-Cal was still a complicated program.

4. The Medi-Cal dental referral program was found to have limited success in increasing access to care.

This referral program was effective in identifying dentists accepting new Medi-Cal patients in only 30 of the state's 58 counties. In the other 28 counties, proxy patients were unable to receive an appointment as a new Medi-Cal patient through the referral program. The low number of providers currently participating in the program, even in the 30 counties, also limits the success of the program. There are only 1,800 dentists in the referral network to serve all the new requests from the approximately 3 million Medi-Cal eligibles in California; if the level of knowledge among Medi-Cal recipients of the existence of the referral program was increased, these proportionately few dentists in the referral program could be overwhelmed with requests, and they might then leave the program.

Conclusion: Access to dental care for Medi-Cal recipients fails to meet minimum federal standards for both participation of dentists and the level of fees paid in Medi-Cal.

The findings of this study indicate that with approximately 16 percent of the dentists in California accepting new Medi-Cal patients, the program is well below the minimum federal regulations for provider participation. The Medi-Cal fee schedules, estimated at less than half of the usual and customary fees in California, are also below federal standards. The low fees are not consistent with the prevailing community fee structures and discourage providers from participating in the program, thus reducing access to dental services.

Federal regulations indicate that at least two-thirds of the providers in a state should be participating in the Medi-Cal program. The regulations were strengthened in the federal Omnibus Budget Reconciliation Act of 1989, which states that fees should be set to encourage enough dentists to participate so that Medi-Cal recipients have the same access to dental services as persons with private insurance coverage in their same geographic area.

RECOMMENDATIONS

To approach the federal standards for access to care, the Medi-Cal dental program will need to attract a significant number of new dentists to the program.

Based on information from interviews with both dentists who do and do not participate in Medi-Cal, the authors offer the following recommendations for the Medi-Cal dental program:

1. Significantly increase reimbursable fees to a level above overhead costs.

Most dentists realize that Medi-Cal will not be able to pay their usual fees. However, if the program is going to attract a significant number of new dentists who can provide quality care, a substantial fee increase is needed. If it is not large enough, it will sim-

ply add to the incomes of currently participating dentists and not attract new ones. An overall average increase of at least 50 percent would place Medi-Cal dental fees at a level that approximates overhead costs.

This fee increase could be implemented so that preventive and basic restorative services were increased 100 percent, with smaller increases for the more expensive procedures such as root canals, dentures, and crowns (caps). This would provide dentists with a small profit for those procedures most often provided Medi-Cal recipients, while overall costs to the Medi-Cal program for the more expensive procedures would remain about the same. It would also encourage dentists to perform primarily preventive, basic restorative, and emergency procedures for Medi-Cal patients.

Future fee increases could be tied to the consumer price index so that dentists deciding whether to participate in Medi-Cal could be assured that current fee increases will continue to be adequate in the future.

2. Simplify administrative procedures.

Making Medi-Cal dental claim forms similar to other insurance forms (instead of the present use of a unique coding system) would ease the paperwork burden, especially for solo practitioners with small office staffs – the majority of dentists in California.

As is the case with most private dental insurance programs, Medi-Cal could also eliminate the requirement that X-rays or written explanations be submitted for routine procedures, such as fillings, on adult patients. (Medi-Cal has removed this requirement for children.) The presubmission of X-rays for routine procedures increases the cost of service and does little to prevent fraud or to increase quality care. Many of the dentists interviewed complained that they were denied payment because of poor-quality X-rays – not because the film was not diagnostic. In order to be reimbursed, they had to take more X-rays, thus exposing patients to additional radiation.

3. Add dental sealants and a second cleaning to the services covered by Medi-Cal.

The Medi-Cal dental program has one of the most complete benefit packages for dental services of any Medicaid dental program in the country. However, there are two common preventive services that are lacking, which, if added, would increase the oral health of Medi-Cal recipients. The first is the use of dental sealants, and the other is the addition of a second cleaning per year, which would benefit many Medi-Cal patients whose periodontal (gums) health status may be poor. The addition of these two services would be a relatively low-cost way to improve care and also decrease the perception among some dentists that Medi-Cal does not allow comprehensive care.

4. Keep dentists up to date about the Medi-Cal dental program.

Most of the dentists interviewed who were not participating in the program had accepted Medi-Cal patients in the past. Some left because of the growth of their practice, but many more stopped accepting new patients because of the problems outlined here, such as low fees and complex paperwork.

In addition, over half the dentists interviewed were unaware of changes in the program, such as a fee increase just two months prior to the interview.

Medi-Cal will need to make an effort, possibly with the help of local dental societies, to keep dentists up to date on the current status of the program and to increase trust among those who stopped accepting Medi-Cal patients.

5. Educate patients about the benefits and responsibilities of the program.

In response to dentists' concerns about broken appointments and patients who are unaware of the dental program, Medi-Cal could provide recipients with information about the program at the time they receive their benefits. This information could include the toll-free phone number for the Medi-Cal referral

service and could explain the importance of arriving on time for appointments.

With increased provider participation, the CHDP program could provide low-income families with information about the dental service available for their children, along with a better chance of finding a dentist for their treatment.

6. Increase access to and accuracy of the Medi-Cal dental referral program.

The survey of the referral program indicated that the program may help match some Medi-Cal patients with dentists, but it is limited in its ability to improve access because so few dentists are accepting new Medi-Cal patients.

If other changes in the Medi-Cal program encouraged a significant number of new providers to begin accepting new patients, the program could have a positive impact on the access to dental services for Medi-Cal patients. It is also important that the referral program regularly update its list of participating dentists to increase the accuracy of the names provided.

The ideal way to increase access to dental services for low-income patients in California would be for every dentist in the state to accept a small number of Medi-Cal patients in their practice. It could be argued that if the state made significant improvements in the Medi-Cal program, enabling dentists to provide dental care to low-income residents while making a small profit, dentists in California might be motivated to view new program participation as worthwhile, as well as a moral and ethical obligation.

Peter C. Damiano, D.D.S., M.P.H., is a visiting assistant professor and Robert Wood Johnson scholar in Health Services Research, UCLA School of Dentistry; E. Richard Brown, Ph.D., is an associate professor in the School of Public Health, UCLA; Jeffrey D. Johnson, D.M.D., M.P.H., is a visiting associate professor and Robert Wood Johnson scholar in Health Services Research, UCLA School of Dentistry; and James P. Scheetz, Ph.D., is a visiting scholar in the School of Public Health, UCLA.

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[Whereupon, at 12 p.m. the hearing was adjourned.]